
# A Program for the Treatment of Pathological Gambling:

# Program Participation and Treatment Outcomes

## RCW 67.70.350(5)

## November 1, 2003

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Special recognition:

A program evaluation of this magnitude requires the coordinated efforts of a number of individuals and organizations who deserve special recognition: first and foremost, the clients and their families, and the treatment providers.

This project could not have been completed without the following individuals: Kenneth D. Stark, Director, Division of Alcohol and Substance Abuse; Deborah Miller Rost, Program Administrator, Washington State Council on Problem Gambling; Loreen Rugle, Ph.D. and Joanna Franklin of Trimeridian for training; Daniel Bissonnette for administering the program; Stephen Bogan, Division of Alcohol and Substance Abuse, for administering the contract for the state of Washington and for helping with the planning, organization, and establishment of the program; Charles Maurer, Ph.D. for his clinical expertise in establishing the program; Ruby Takushi, Ph.D., for oversight and coordination of the evaluation.

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## EXECUTIVE SUMMARY

In 2002, the Washington State Legislature established a program for the treatment of pathological gambling. Language in the 2002 legislation (E2SSB 6560) included the establishment of a program for those who need and are amenable to treatment but who are unable to afford treatment themselves. The Department of Social and Health Services (DSHS) contracted with the Washington State Council on Problem Gambling (WSCPG) to administer the gambling treatment program. The WSCPG recruited and trained qualified treatment providers, adopted treatment and referral protocols, and developed and assured completion of outcome measures.

This report fulfills a requirement of RCW 67.70.350(5) and represents an evaluation of state-supported pathological gambling treatment in Washington. It describes a longitudinal study representing all clients who were recruited from between October 2002 and June 2003. The pilot program was implemented within the $500,000 one-time appropriation. Implementation began July 1, 2002, and treatment services began in October 2002 and continued through June 30, 2003. Approximately 226 clients and family members were served during the nine-month duration of the program. The effectiveness and success of the program was assessed using a client satisfaction survey instrument and treatment outcome-monitoring instrument for analysis. The majority of clients involved in the pilot program ended their treatment due to the fact that funding was not continued.

### Treatment Program Goal

The primary goal of this pilot program was to provide assistance to families dealing with pathological gambling. The program was designed to help individuals quit addictive gambling behavior, and reduce family disruption and related financial problems. Through gambling addiction treatment, the program sought to help families remain economically self-sufficient without requiring further assistance from other state programs. For those who had already lost jobs, the program sought to help them become productive, taxpaying citizens.

### Definition of Pathological (Problem) Gambling

According to the American Psychiatric Association (1994), the essential features of pathological gambling are:

- A continuous or periodic loss of control over gambling;
- A progression, in gambling frequency and amounts wagered, in the preoccupation with gambling and in obtaining monies with which to gamble; and
- A continuation of gambling involvement despite adverse consequences.

The term "problem gambler" has been introduced to describe these individuals, who may be in an early stage of pathological gambling. The term is also used as a more inclusive category that encompasses pathological gambling at one end of a continuum of problematic gambling involvement. In this sense, problem gambling can be defined as any

pattern of gambling behavior which compromises, disrupts or damages family, personal or vocational pursuits (Lesieur & Rosenthal, 1991).

## The Need for the Program

According to the 1999 study *Gambling and Problem Gambling in Washington State: A Replication Study, 1992 to 1998,* over 400,000 Washington State residents scored as being either problem (144,600) or pathological (270,900) gamblers during their lives. In addition, between 53,200 and 137,900 scored as either being problem gamblers or pathological gamblers over the last year.

A second study, *Gambling and Problem Gambling Among Adolescents In Washington State: A Replication Study, 1993 To 1999,* found that between 25,730 and 44,000 adolescents scored as either being problem gamblers or gambled at levels which placed them at risk for gambling problems. Furthermore, this study found that adolescents represented approximately 12% to 18% of Washington State residents who are experiencing severe difficulties related to their gambling.

Problem and pathological gambling generally results in severe problems for the gambler, his or her family, and for society. Individually, up to 40% of problem and pathological gamblers are also addicted to drugs and/or alcohol. The suicide rate for pathological gamblers is second only to those with clinical depression. Problem gamblers have very high rates of gastrointestinal and cardiac illness. Rates of spousal abuse and child neglect are high and families may face severe financial problems. Families often lose their homes and become dependent on state services. The societal problems associated with problem and pathological gambling include bankruptcy, criminal activity/illegal acts, and disruption of work and educational activity.

## Program Development

Program development for the Washington State Pilot Program included the following:

- Workforce development – advance training of certified treatment professionals;
- Acquisition and distributions of treatment manuals;
- Professional training for treatment providers;
- Professional supervision for treatment providers;
- Client and community outreach;
- Client retention within the treatment program; and
- Outreach to currently certified alcohol and drug treatment agencies.

## Client Criteria

### *Financial Eligibility*

The financial components of pathological gambling differ from other addictions. Pathological gamblers may maintain an income, but often have a level of debt causing

severe family disruption and hardship. Since it was a goal of treatment to reduce family disruption, economic problems, and the costs to society and the state associated with pathological gambling, a sliding scale was developed for payments based on income-to-debt ratios determined during the first four assessment/treatment sessions.

Experience in other states, including Nebraska and Oregon, indicated that clients will understate the level of debt during initial evaluation and that the true extent of debt cannot be determined until a later session. Therefore, four treatment sessions were funded at no cost to the client before the establishment of the income-to-debt ratio. Some clients qualified for a mix of private-pay/third-party and state-funded treatment, with DSHS being the payor of last resort.

*Assessment Criteria*

To qualify for treatment, clients must have met the diagnostic criteria for problem/pathological gambling as defined by at least one of the following screening instruments:

- Obtain a score of five or above on the South Oaks Gambling Screen – Revised (SOGS-R).
- Meet three criteria for Pathological Gambling contained in the Diagnostic and Statistical Manual – IV (DSM-IV) based on a Diagnostic Interview for Gambling Severity (DIGS) score of at least 3. (DIGS developed by Winters and Stinchfield, University of Minnesota Medical School 1995).
- Be a significant other(s) of an individual meeting the above criteria based on screening data provided.

*Screening for inclusion*: Individuals were screened in several ways including through the WSCPG help-line and website and through existing referral networks. If clients had additional disorders requiring intervention, they were triaged to more appropriate treatment options.

*Intake/Referral Protocols:* The original intake process involved giving WSCPG Help Line caller's two to three referrals to qualified providers. This approach was modified to include informing the callers that, with their permission, a treatment provider would call them back within 24 hours. This increased the number of initial client-provider contacts completed.

**Treatment Providers**

*Treatment Provider Location*

To achieve the highest amount of treatment availability per population, the twenty-five treatment providers were identified in at least five geographic areas of the state. They are the Puget Sound region (including Everett, Seattle, and Tacoma), Bellingham, Vancouver, Yakima, and Spokane.

*Qualifications, Educational Level, Professional Certification, and Ethnicity of Gambling Treatment Providers*

Gambling treatment providers selected to provide gambling treatment under this program included existing nationally or state-certified gambling counselors, certified Chemical dependency (CD) outpatient, inpatient treatment programs, independent treatment professionals, or any combination of the above.

Providers included eight Ph.D. Psychologists, 11 Chemical Dependency Professionals, and six Licensed Mental Health Counselors. Ethnic diversity of providers included two Native Americans, one Hispanic, and three Asian Americans (Chinese, Korean, Japanese). (Included bi-lingual capability.)

## Treatment Protocols

Treatment protocols were based on state-of-the-art clinical manuals developed at the Trimeridian Treatment Center in Indiana. Treatment manuals were provided to every clinic/treatment provider approved to participate as a practitioner under this pilot, insuring standardized treatment. In addition, patient manuals were provided to program clients. These patient manuals provided gambling addiction recovery information for clients and their families.

## Training, Supervision of Treatment Providers

In order to insure a high quality of treatment, all initial treatment providers authorized under this pilot program were required to attend four days of training. These trainings were provided at no cost to the providers, but attendance was mandatory for all participating providers. The training included:

- General information about program requirements and operations. WSCPG staff provided this one-day training in several regions of the state.
- Three days of clinical training were offered one time only at a single location. An outside contractor (Trimeridian) with extensive experience provided the training.

*Professional Supervision of Treatment Providers*

Professional supervision was required for those selected providers not currently certified as problem gambling counselors. One hour of supervision was required for every ten hours of client treatment. Approved supervisors were certified Problem Gambling Counselors.

## Treatment Model

Treatment focused on outpatient services, with abstinence as an ultimate goal. Secondary goals of engagement and retention including limited harm reduction may be used for working with treatment-resistant clients. Financial counseling is a mandatory part of treatment and will be a significant aspect of provider training.

Duration of treatment is determined by the clinical needs of the client and family. A treatment model of 12 weeks duration was utilized. Enrollment of at least 200 participants was anticipated and reached during the nine-month pilot period. Treatment modalities included:

- Individual and/or family member treatment;
- Group treatment for the individual and family;
- Couples treatment;
- Financial counseling;
- Referral to Gamblers Anonymous and other 12-Step groups;
- Family intervention; and
- Referrals to other appropriate community resources.

**Measuring Program Effectiveness and Client Outcomes**

The effectiveness and success of the program was assessed using several instruments, including:

- Client satisfaction survey using an existing instrument from the state of Nebraska.
- Treatment outcome monitoring/analysis using an existing instrument from the state of Minnesota.
- DSHS/Division of Alcohol and Substance Abuse (DASA) required information related to demographic data and links to employment and utilization of medical services.

**Outreach/Notification**

*Outreach to providers*

All Washington State providers currently certified as gambling counselors nationally or by WSCPG were solicited as to their interest in serving as a provider, supervisor and/or consultant for the pilot project. In addition, the DASA and the WSCPG notified all certified chemical dependency treatment providers about the program.

**Outreach to Clients/Public**

WSCPG utilized the following agencies and organizations to inform the public and potential clients about the availability of treatment under this pilot program.

- Gamblers Anonymous
- Tribal treatment/social service agencies
- DASA contracted providers
- County human service organizations
- Community leaders
- WSCPG help-line services

- Mental health services
- Professional associations
- Media outlets

Gambling program treatment providers offered over 86 hours of community outreach aimed at increasing awareness of problem gambling.

**Outcome Evaluation Client Recruitment**

During the study period, 203 clients were recruited for the study. Admission rates increased from the inception of the gambling treatment project and have leveled off at about an average of 13 admissions per month. This leveling off was in part due to the necessary termination of treatment services on June 30, 2003, due to the fact that funding was not continued.

Of the 203 recruited clients, 23 were not admitted to treatment, primarily because they either did not return to treatment after their intake assessment or because they came to a treatment provider for only an assessment, and 63 did not complete the admission questionnaire, or their therapist did not complete the Gambling Treatment Services Questionnaire, both of which are required to include them in the study.

Among the 117 clients admitted to treatment and who had completed both admission and gambling services questionnaires, 47 completed treatment. Clients were administered a follow-up assessment at three months after treatment.

**Three-Month Longitudinal Follow-up Sample Recruitment**

Only those clients who reached their three-month post-discharge anniversary were eligible for the follow-up, and not all of the 117 clients had reached their three-month follow-up date by the time this report was written. Approximately 99 of the 117 clients were eligible for follow-up through September 2003. Of the other 18 clients, eight were discharged in July 2003 and ten clients did not have a discharge date in the database. Of those 99 clients eligible for follow-up by the time of this report, 33 provided follow-up data, for a response rate of 33%. The termination of treatment services due to the end of funding on June 30, 2003, limited the number of clients in the longitudinal study follow-up sample. The follow-up sample included both completers and non-completers.

**Client Demographics**

Of the 117 clients who were admitted to treatment and who completed the admission questionnaire:

- 48% were male;
- average age was 43;
- 73% were white;

- 81% were high school graduates and 19% were college graduates; and
- 60% were employed full-time.

### Clinical History of Gambling and Co-Occurring Problems

Of the 117 clients who were admitted to treatment and who completed the admission questionnaire:

- Almost half of the sample had previously sought help for their gambling problem.
- One-quarter had received substance abuse services and half had used mental health services.
- Nearly all clients received a diagnosis of pathological gambling and obtained a South Oaks Gambling Screen (SOGS) score in the probable pathological gambler range.
- One quarter of the sample began gambling before adulthood (27% before age 18).
- The two most preferred gambling activities were cards (47%) and gambling machines (46%).
- In the twelve months prior to treatment, 13% of the sample gambled on a daily basis and two-thirds gambled at a weekly rate (66%).
- Debt due to gambling ranged from zero to hundreds of thousands of dollars with an average of $30,000 and a median of $10,000.
- Over half of the sample (61%) reported that they had been absent from work due to gambling on one or more days during the twelve months prior to treatment.
- One in seven clients reported they had a legal status of either being on parole, probation, or were awaiting charges, trial or sentencing as a result of gambling-related legal problems.
- In terms of substance use, half reported daily tobacco use, and almost one-third were weekly to daily alcohol users. Very few reported a history of illicit drug use.

## CORE FINDINGS

### Client Outcomes at Three-Months Indicates a Reduction in Gambling Behaviors and Other Problems

- One-third of the sample was abstinent (from gambling) and another third had gambled less than once per week. There was a statistically significant decline in gambling frequency from an average of gambling one to seven days per week before treatment to an average of less than once per month at discharge and at three-months follow-up.
- In terms of clinically significant change on gambling frequency, over half of the sample moved from the clinical range to the normative range between admission and three-months follow-up.
- SOGS scores declined significantly, from an average of 13 at admission to an average of six at three-months follow-up. DSM-IV scores declined significantly from an average of eight at admission to an average of three at three-months follow-up.

- Financial problems decreased from an average of ten at admission to an average of two at three-months follow-up.
- Illegal behavior decreased from an average of one at admission to zero at three-months follow-up.
- The number of days of conflict with family members decreased from an average of three at admission to an average of one at three-months follow-up.
- Mental health functioning improved from admission to discharge as demonstrated by statistically significant improvements on the BASIS-32 scales of Relation to Self/Others, Depression/Anxiety, Daily Living Skills, Impulsive/Addictive Behavior, Psychosis, and the overall BASIS-32 scale.

**Client Satisfaction**

- The majority of clients were satisfied with the treatment services they received and attributed their improvement to the treatment program.

**Conclusions**

- Results from the study suggest that the treatment was influential in the improvement of clients.
- Even though many clients did not complete the full course of treatment, they still exhibited improvement at follow-up.
- Approximately 90% of clients discontinued treatment because the program services were terminated due to funding ending on June 30, 2003. Clients reported they would have liked to continue treatment but were unable to find other services due to lack of insurance coverage and funding barriers.

## Testimonials for the Problem Gambling Treatment Program

***Excerpt from letter written by Faye, a client in the Problem Gambling Treatment Program.***

"I got out of jail in a nightgown with pouring rain. I walked around and felt so low I wanted to commit suicide. I found a phone number and called. I told them I desperately needed help now. Now that I am going through the state pilot program I pray it does not end. I need this help. Dr. Cornish [a provider working in the program] saved my life and I know there are thousands more …"

***Excerpt for letter written by Jackie, of Yakima Washington, a client in the Problem Gambling Treatment Program.***

"I have over the course of several years sought out whatever help was available in this area to people like me who suffer with a compulsive gambling problem. I could not even get a sponsor through the local GA [Gambler's Anonymous] group. I had looked into in-patient treatment centers offering this program. The closest one was in Montana and not

economically feasible for me. My insurance wouldn't help with any of the cost. And being a compulsive gambling, I did not have several thousand dollars in my checking account. I am very hopeful now that I finally have the opportunity to find the help I have sought out and needed for several years."

***Excerpt for letter written by Steve, a professional treatment provider, working in the Problem Gambling Treatment Program.***

"I believe that due to the tremendous financial problems that pathological gamblers create for themselves, it is unlikely that any of the clients would have had the financial ability to access treatment without the PGTP [Problem Gambling Treatment Program]. The families who seek help for themselves, while also attempting to engage their partner (gambler) in the treatment process, are given hope where there was none, and are empowered by learning about this addiction."

## INTRODUCTION TO THE OUTCOME REPORT

Pathological gambling is a serious addiction that can have devastating effects on both the person with the addiction and his/her family. It is estimated that approximately one to three percent of the general population are pathological gamblers (American Psychiatric Association, 1994). The two cardinal signs of pathological gambling are loss of control and continued gambling in spite of adverse consequences (American Psychiatric Association, 1994).

A program for the treatment of pathological gambling was established within the Washington Department of Social and Health Services. To receive treatment a person must need treatment for pathological gambling, but be unable to afford treatment. The primary goal of this program is to provide assistance to families affected by pathological gambling. The program is designed to help individuals quit addictive gambling behavior, and reduce family disruption and related financial problems. Through gambling addiction treatment, the program sought to help families remain economically self-sufficient without requiring further assistance from other state programs.

Duration of treatment was determined by the clinical needs of the client and family. A treatment model of up to 12 weeks duration was utilized. Enrollment of at least 200 participants was anticipated during the nine-month pilot period. Treatment modalities included:

- Individual and/or family member treatment;
- Group treatment for the individual and family;
- Couples treatment;
- Financial counseling;
- Referral to Gamblers Anonymous and other 12-Step groups;
- Family intervention; and
- Referrals to other appropriate community resources.

This study includes only those pathological gamblers who came to one of the designated gambling treatment providers and in no way presumes to represent all pathological gamblers seeking treatment in the state of Washington. There are other pathological gamblers seeking treatment from other mental health services, such as private mental health practitioners, community mental health centers, and mental health services of health maintenance organizations.

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## RESEARCH QUESTIONS

This study investigated the outcome of clients treated by gambling treatment providers. The study addresses the following questions:

(1) What are the demographic characteristics and clinical history of gamblers seeking treatment?

(2) What is the level of severity of the client's gambling problem at admission?

(3) What treatment components do clients rate as helpful?

(4) Are clients satisfied with their treatment?

(5) Do clients abstain from or reduce gambling involvement during the course of outpatient treatment and at follow-up?

(6) Do clients function well in the areas of social and vocational responsibilities following treatment?

(7) Do clients participate in post-treatment recovery services (e.g., aftercare and GA meetings)?

## DESIGN

This study involves a pretest-posttest design. Assessments were conducted at admission, discharge, and three-months follow-up after discharge. Table 1 presents the measurement points and content of questionnaires.

**Sample Recruitment.** During the intake assessment, treatment staff informed clients about the research project and invited them to participate in the study. Clients who agreed to participate signed an informed consent form and were given a copy of the consent form.

**Instruments.** All of the instruments were paper and pencil questionnaires completed by the client. In addition, a significant other was asked to provide information about the client's behavior by completing questionnaires at admission and follow-up. This information from the significant other was obtained to corroborate the client's self-report. Furthermore, treatment staff record clinical data on a discharge form. For more information about the psychometric properties of the instruments used please see Stinchfield (1999) and Stinchfield and Winters (2001).

**Data collection.** Treatment program staff administered admission and discharge questionnaires and research staff collected follow-up data. Treatment and research staff members were trained in the administration of assessment instruments. Treatment program staff administered admission and discharge questionnaires to clients and a significant other. At discharge, treatment program staff completed the Gambling Treatment Services Questionnaire. All of these admission and discharge questionnaires were then delivered to the research office for data entry. Follow-up questionnaires were mailed to clients and significant others at three months after discharge from treatment. A stamped, self-addressed return envelope was enclosed with the questionnaire. Those clients, who did not respond to the mailing, were then called on the telephone and administered the follow-up instrument over the phone.

**Table 1**

**STUDY DESIGN:**
**MEASUREMENT POINTS AND CONTENT OF QUESTIONNAIRES**

| Admission | Discharge | Three-months Follow-up |
|---|---|---|
| Demographics | | Demographics |
| Clinical history | | |
| Gambling behaviors | | Gambling behaviors |
| Gambling frequency | Gambling frequency | Gambling frequency |
| SOGS | | SOGS |
| DSM-IV Diagnostic Criteria | | DSM-IV Diagnostic Criteria |
| Stage of Change | Stage of Change | Stage of Change |
| Financial problems | | Financial problems |
| Legal problems | | Legal problems |
| Substance use frequency | | Substance use frequency |
| Psychosocial problems | | Psychosocial problems |
| BASIS-32 Mental Health | BASIS-32 Mental Health | BASIS-32 Mental Health |
| | Treatment component helpfulness | |
| | Client satisfaction | |
| | Discharge information | |
| | | Post-treatment service utilization |

**Note:** SOGS - South Oaks Gambling Screen (Lesieur & Blume, 1987).

## NUMBER OF CLIENTS RECEIVING SERVICES

Figure 1 presents the number of clients who received services from each of the 19 treatment providers. A total of 203 clients were seen across all 19 treatment providers.

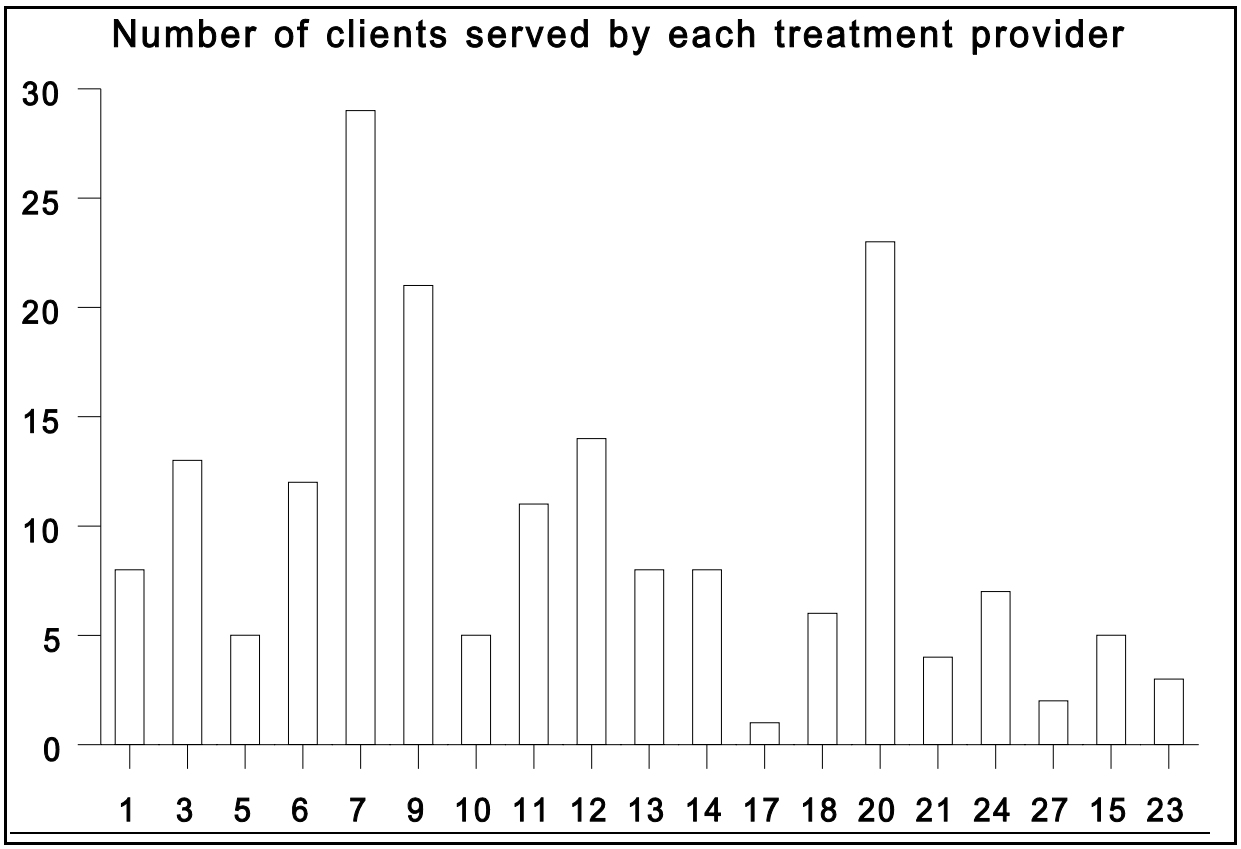


Figure 1

## SAMPLE SIZE

This is a multisite study and clients were recruited from 19 different gambling treatment providers, between October 2002 and June 2003. As would be expected, not all of the clients who were asked to participate in the study agreed to participate, and not all of the clients recruited for the study were admitted to treatment, and not all of those admitted to treatment completed it. Table 2 displays a diagram of sample recruitment, admission, and discharge status. A total of 203 clients agreed to participate. Of the 203 total recruited clients, 41 did not complete a Gambling Treatment Admission Questionnaire (GTAQ). Of the 162 clients with a completed GTAQ, 22 did not have a Gambling Services Treatment Questionnaire (GTSQ) completed by their treatment provider. Of the 140 clients with completed GTAQ and GTSQ, 23 were not admitted to treatment, primarily because they either did not return to treatment after their intake assessment or because they came to a treatment provider for only an assessment. Of the 117 admitted to treatment, 47 completed the treatment regimen, 69 did not complete the entire treatment regimen (including some clients who are still in treatment), and the discharge status of one client was unknown. Reasons for noncompletion included: client left against staff advice (n=20); client left at staff request (n=3); absent without leave (n=20); and transfer to another treatment program (e.g., substance abuse treatment) (n=14); and unknown (n=12). Table 2 shows a breakdown of the recruited sample, admission status, and discharge status.

**Table 2**

**CLIENT RECRUITMENT, ADMISSION, AND DISCHARGE STATUS**

| Consented | Admission Status | Discharge Status |
|---|---|---|
| 203 consented--> | 117 admitted----------> | 47 completed treatment regimen |
| | \--> 23 not admitted | \--> 69 did not complete treatment or still in treatment |
| | \–> 63 missing data | \–> 1 unknown |

## ADMISSION RATES

Admissions rates by month for the 117 clients admitted to treatment from October 2002 through the end of June 2003 are presented in Figure 2. The general trend was that admission rates increased at the inception of the gambling treatment project and averaged about 13 admissions per month. This leveling off was in part due to the termination of treatment services on June 29, 2003, due to the fact that funding was not continued.

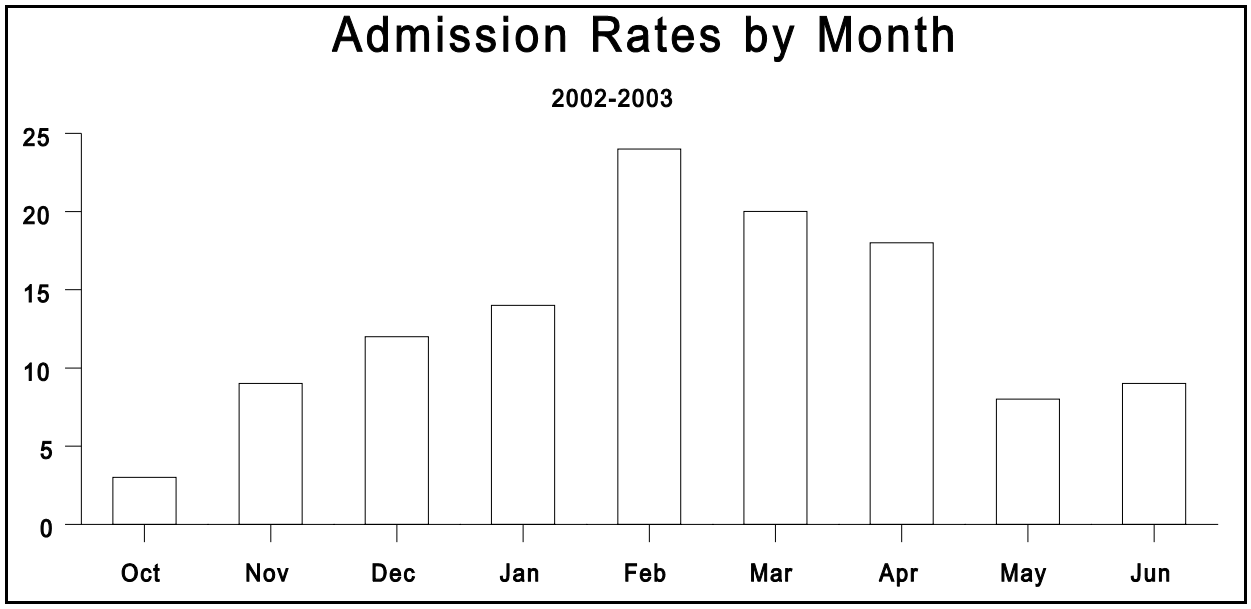


Figure 2

## DATA COLLECTION RATES FOR THE ADMITTED SAMPLE AT INTAKE AND DISCHARGE

Table 3 presents data collection rates for clients admitted to treatment by each discharge status group. Intake questionnaires were collected from 117 clients. Discharge questionnaires were collected from 43 clients and three-months follow-up questionnaires were collected from 33 clients.

**Table 3**

**DATA COLLECTION RATES**
**(N=117)**

| | Questionnaires | | | |
|---|---|---|---|---|
| **Client Discharge Status** | **Client Intake** | **Gambling Treatment Services** | **Client Discharge** | **3-months follow-up** |
| **Treatment Completers (n=47)** | 47 | 47 | 23 | 13 |
| **Treatment Noncompleters (n=69)** | 69 | 69 | 19 | 19 |
| **Unknown discharge status (n=1)** | 1 | 1 | 1 | 1 |
| **Column Totals (n=117)** | 117 | 117 | 43 | 33 |

## DEMOGRAPHICS OF ADMISSION SAMPLE

Table 4 provides a summary of the sample's demographic characteristics. There were slightly more women than men. Almost two-thirds of the sample was between 30 and 49 years of age (average = 43), and three-fourths of the sample was White (73%). In terms of marital status, the sample was fairly evenly divided, with one-third single, one-third married, and one-third currently separated or divorced. About half reported either a moderately or highly skilled occupation, and one in ten was unemployed. The group was fairly well educated: over 80% are high school graduates and half report some college education or graduation from college. However, over half reported an annual household income less than $30,000.

**Table 4**

**CLIENT DEMOGRAPHIC CHARACTERISTICS**

| Client Characteristic | Count | % |
|---|---|---|
| **Gender** | | |
| Male | 56 | 48 |
| Female | 60 | 51 |
| **Age** | | |
| <21 | 1 | 1 |
| 21-29 | 10 | 9 |
| 30-39 | 28 | 24 |
| 40-49 | 41 | 35 |
| 50-59 | 32 | 27 |
| 60+ | 5 | 4 |
| **Race** | | |
| White | 85 | 73 |
| Asian | 13 | 11 |
| African American | 7 | 6 |
| Hispanic | 0 | 0 |
| American Indian | 5 | 4 |
| Other/Mixed Race | 7 | 6 |
| **Marital Status** | | |
| Single/Never married | 34 | 29 |
| Married/partnered/living together | 36 | 31 |
| Widowed | 1 | 1 |
| Separated | 7 | 6 |
| Divorced | 39 | 33 |
| **Number of Children** | | |
| 0 | 39 | 34 |
| 1-2 | 54 | 46 |
| 3-4 | 21 | 18 |
| 5+ | 3 | 3 |
| **Education** | | |
| Did not finish high school | 3 | 3 |
| High School Graduate/GED | 26 | 22 |
| Vocational/technical training | 9 | 8 |
| Some college | 30 | 26 |
| 2-year college degree | 8 | 7 |
| 4-year college degree | 19 | 16 |

| | | |
|---|---|---|
| Graduate degree | 3 | 3 |
| Not reported | 19 | 16 |
| **Occupation** | | |
| Professional/Technical | 5 | 5 |
| Managerial/Administrative | 26 | 25 |
| Sales Worker/Clerk | 20 | 19 |
| Craftsman | 3 | 3 |
| Machine/Transport Equipment Operator | 3 | 3 |
| Laborer | 2 | 2 |
| Service Worker | 11 | 11 |
| Private household worker | 1 | 1 |
| Unknown/Unreported | 32 | 31 |
| **Employment Status** | | |
| Full-time | 70 | 60 |
| Part-time/occasional/seasonal | 19 | 16 |
| Unemployed | 11 | 9 |
| Student | 1 | 1 |
| Homemaker | 3 | 3 |
| Disabled | 9 | 8 |
| Retired | 4 | 3 |
| **Annual Household Income** | | |
| < $10,000 | 17 | 15 |
| $10,000-$20,000 | 26 | 22 |
| $20,000-$30,000 | 19 | 16 |
| $30,000-$40,000 | 20 | 17 |
| $40-000-$50,000 | 8 | 7 |
| $50,000-$75,000 | 15 | 13 |
| $75,000-$100,000 | 4 | 3 |
| > $100,000 | 4 | 3 |
| Not reported | 4 | 3 |

## CLINICAL AND TREATMENT HISTORY

Table 5 indicates that nearly half of the sample had previously sought help for gambling problems (with the overwhelming majority of this help being in the form of Gamblers Anonymous). Prior use of other treatment services was fairly common as well: almost one-third had received alcohol/drug abuse treatment and half had used mental health services.

**Table 5**

**CLINICAL AND TREATMENT HISTORY**

| | Count | % |
|---|---|---|
| **Main reason you came to treatment** | | |
| Court-ordered/legal difficulties | 12 | 10 |
| Family pressure | 28 | 24 |
| Work/employer pressure | 2 | 2 |
| Client's own decision | 39 | 33 |
| Financial difficulties | 30 | 26 |
| Other | 2 | 2 |
| **Prior Individual Treatment for Gambling** | 44 | 38 |
| **Prior Group Treatment for Gambling** | 35 | 30 |
| **Prior Treatment for Tobacco Addiction** | 10 | 9 |
| **Prior Treatment for Alcohol/Drug Addiction** | 31 | 27 |
| **Prior Treatment for other addictions** | 9 | 8 |
| **Prior Treatment for mental health problems** | 59 | 50 |
| **Prior GA Participation** | 58 | 50 |
| **Stage of Change at Admission** | | |
| 1. Pre-Contemplative | 2 | 2 |
| 2. Contemplative | 22 | 19 |
| 3. Preparation | 33 | 28 |
| 4. Action | 49 | 42 |
| 5. Maintenance | 8 | 7 |

## PRE-TREATMENT GAMBLING BEHAVIOR

Table 6 summarizes several pretreatment gambling variables, including onset of regular gambling, preferred games, absenteeism from work, and amounts of money lost gambling. There are two predominantly preferred games, cards (blackjack) and gambling machines such as slot machines and video lottery terminal (VLTs). Almost half of the sample preferred cards and the other half preferred gambling machines. There were only five clients who preferred other games such as keno or the lottery.

Gambling onset data indicate that initial gambling prior to adulthood was common. Almost one-third started gambling prior to age 19 and over one-half started gambling prior to age 22. One-quarter of the sample began regular gambling, defined as weekly or more often, within the past three years. Almost one-third began regular gambling between three and ten years ago and another one-third began regular gambling over ten years ago. Therefore, a fairly large proportion of the sample had recent onset of regular gambling and developed problems with gambling quickly.

Over half (61%) of the sample had missed work due to gambling in the twelve months prior to treatment. The average number of days absent from work was nine days in the past year. Losing large amounts of money in a single day was commonly cited. Over one-half of the sample indicated that they had lost over $1,000 in a day and one-fifth had lost $5,000 or more in a single day.

In terms of gambling problem severity, 90% of the sample obtained scores on the SOGS and DSM-IV over the clinical threshold of five or more for both measures. The average SOGS score was 13 and the average DSM-IV score was eight. This represents serious problem severity and few clients were even near the cut score of five for both measures.

**Table 6**

**PRE-TREATMENT GAMBLING BEHAVIOR**

| | Count | % |
|---|---|---|
| **Preferred Game** | | |
| Cards (blackjack, 21) | 55 | 47 |
| Gambling machines (slot machines, VLTs) | 54 | 46 |
| Keno | 2 | 2 |
| Lottery | 1 | 1 |
| Dice games | 2 | 2 |
| **Age of first gambling** | | |
| <18 | 31 | 27 |
| 18-21 | 33 | 28 |
| 22-29 | 19 | 16 |
| 30-39 | 19 | 16 |
| 40+ | 9 | 8 |
| **Onset of regular gambling (weekly or more)** | | |
| within the past year | 19 | 16 |
| > 1 year and less than 3 years ago | 23 | 18 |
| > 3 years ago and less than 10 years ago | 35 | 30 |
| >= 10 years ago | 37 | 33 |
| **Work absenteeism due to gambling** | 71 | 61 |
| **Largest amount of money lost in one day** | | |
| $0 | 0 | 0 |
| $1-$99 | 1 | 1 |
| $100-$999 | 34 | 29 |
| $1,000-$4,999 | 57 | 49 |
| >$4,999 | 22 | 19 |
| **SOGS score of 5+** | 106 | 91 |
| **DSM-IV score of 5+** | 105 | 90 |

## PRE-TREATMENT GAMBLING FREQUENCY

Table 7 presents gambling frequency for the twelve-month period prior to admission to treatment. Gambling activities were rank ordered in the table based on the highest to lowest "Daily" gambling percentage. Two types of gambling stand out as the most frequently played: gambling machines (slots and VLTs) and cards (blackjack, 21). The prevalence of weekly or daily involvement with these games was 47% for gambling machines and 37% for cards.

Also reported in Table 7 are frequencies for the highest level of gambling across all activities. This variable was created in order to have a single score that represents an individual's overall or highest level of gambling frequency. It was computed by selecting the highest level of gambling for clients by looking across all of their gambling activities. For example, if an individual bought lottery tickets daily, played blackjack once/month, and played slot machines once/week, their highest level of gambling frequency would be "daily." This "high-water" measure of gambling involvement indicates that high frequency gambling is common among clients. About one in seven (13%) indicated that they were daily gamblers and an additional 66% were gambling multiple days per week.

**Table 7**

**PRETREATMENT GAMBLING FREQUENCY BY GAME**
**(Percentage)**

| Game | Never % | less than once month % | 1 - 3 days month % | 1 - 2 day /week % | 3 - 6 days week % | Daily % |
|---|---|---|---|---|---|---|
| **Gambling machines (slots, VLTs)** | 23 | 15 | 15 | 22 | 21 | 4 |
| **Cards** | 34 | 13 | 12 | 15 | 19 | 3 |
| **Lottery** | 24 | 30 | 21 | 14 | 8 | 3 |
| **Keno** | 79 | 11 | 3 | 3 | 4 | 1 |
| **High risk investing** | 97 | 2 | 0 | 0 | 0 | 1 |
| **Pull-tabs** | 55 | 33 | 8 | 2 | 1 | 0 |
| **Sports Betting** | 85 | 12 | 1 | 1 | 2 | 0 |
| **Personal sports** | 80 | 16 | 2 | 1 | 1 | 0 |
| **Bingo** | 77 | 13 | 4 | 3 | 1 | 0 |
| **Horse/dog racing** | 87 | 11 | 1 | 0 | 0 | 0 |
| **Dice games** | 81 | 10 | 3 | 0 | 3 | 0 |
| **Highest level of gambling** | 3 | 2 | 17 | 26 | 40 | 13 |

## PRE-TREATMENT GAMBLING-RELATED DEBT AND FINANCIAL PROBLEMS

Table 8 presents gambling-related debt and financial problem data. Almost one-half (44%) of the samples reported a current gambling debt of at least $10,000, with 4% reporting debt in excess of $100,000. The average gambling-related debt was $30,000 with a median of $10,000.

Table 8 presents gambling-related financial problems that the client reported at admission. The majority of clients noted borrowing household money (76%), followed by borrowing money from credit cards, and borrowing money from their spouse and other relatives. Almost one in five has filed for bankruptcy. Gamblers can be quite ingenious in obtaining money with which to gamble. The average number of financial problems out of a possible 31 problems was ten.

| Table 8<br>GAMBLING-RELATED FINANCIAL PROBLEMS | | |
|---|---|---|
| **Gambling-Related Financial Problems** | **Count** | **%** |
| **Debt** | | |
| $0-$999 | 13 | 11 |
| $1,000-$4,999 | 22 | 19 |
| $5,000-$9,999 | 11 | 9 |
| $10,000-$24,999 | 21 | 18 |
| $25,000-$49,999 | 10 | 9 |
| $50,000-$99,999 | 15 | 13 |
| > $100,000 | 5 | 4 |
| Not reported | 20 | 17 |
| Borrowed household money | 89 | 76 |
| Borrowed from spouse | 41 | 35 |
| Borrowed from other relatives | 58 | 50 |
| Borrowed from banks | 54 | 46 |
| Borrowed from credit cards | 73 | 62 |
| Borrowed from loan sharks | 16 | 14 |
| Cashed in stocks, bonds, securities | 24 | 21 |
| Sold personal or family property | 46 | 40 |
| Borrowed from checking account | 74 | 63 |
| Took out a second mortgage on home | 16 | 14 |
| Been unable to pay taxes | 29 | 25 |
| Filed bankruptcy | 20 | 17 |
| Unable to pay mortgage/rent | 42 | 36 |
| Unable to pay utilities | 44 | 38 |
| Unable to pay credit card debt | 54 | 46 |
| Unable to pay for food or clothing | 51 | 44 |
| Unable to pay medical expenses | 36 | 31 |

## PRE-TREATMENT GAMBLING-RELATED ILLEGAL BEHAVIOR AND ARRESTS

Table 9 provides a summary of gambling-related behaviors and arrests. It is interesting to note that many more clients have committed illegal acts, than have been arrested for these acts. One in six clients (15%) reported a current legal status of either being on parole, probation, or awaiting charges, trial or sentencing.

**Table 9**

**LEGAL PROBLEMS**

| Illegal Behaviors | Ever done it? | | Arrested? | |
|---|---|---|---|---|
| | Count | % | Count | % |
| **Forgery/counterfeit** | 18 | 15 | 1 | 1 |
| **Theft by check** | 50 | 43 | 1 | 1 |
| **Embezzlement** | 13 | 11 | 3 | 3 |
| **Robbery or burglary** | 5 | 4 | 2 | 2 |

## PRE-TREATMENT SUBSTANCE USE

Substance use frequency for the twelve months prior to admission is presented in Table 10. Tobacco and alcohol were the most commonly used substances. One half of the sample reported daily use of tobacco, and almost one-third reported weekly to daily use of alcohol. Other drugs were, for the most part, not used or rarely used on a weekly/daily basis.

**Table 10**

**PRE-TREATMENT SUBSTANCE USE FREQUENCY (Percentage)**

| Game | Never | less than once/month | 1-3 days /month | 1-2 days /week | 3-6 days /week | Daily |
|---|---|---|---|---|---|---|
| **Tobacco** | 36 | 3 | 0 | 1 | 4 | 50 |
| **Alcohol** | 28 | 15 | 24 | 13 | 11 | 5 |
| **Marijuana** | 77 | 6 | 3 | 1 | 2 | 3 |
| **Other Drugs** | 84 | 3 | 1 | 2 | 0 | 2 |

## PRE-TREATMENT PSYCHOSOCIAL PROBLEMS

Client ratings of psychosocial problems with family and with others in the 30 days prior to treatment are summarized in Table 11. Over one-half (56%) reported at least one or more days of serious conflict with family members and almost one-third (28%) reported serious conflict with others.

**Table 11**

**PRE-TREATMENT PSYCHOSOCIAL PROBLEMS**

| | Count | % |
|---|---|---|
| **Days of serious conflict with family in the past 30 days** | | |
| 0 | 42 | 36 |
| 1-5 | 46 | 39 |
| 6-10 | 9 | 8 |
| 11+ | 11 | 9 |
| **Days of serious conflict with other people in the past 30 days** | | |
| 0 | 70 | 60 |
| 1-5 | 28 | 24 |
| 6-10 | 5 | 4 |
| 11+ | 0 | 0 |

## TREATMENT INTENSITY

Table 12 presents information regarding the amount of treatment received by clients who completed treatment and those who did not complete treatment. Treatment intensity is presented by total number of therapy sessions, hours of assessment and hours of individual therapy.

Among clients who completed treatment (n=47): the number of sessions ranged from two to 41, with an average of 13 sessions; hours of assessment ranged from zero to five with an average of 2.7; and hours of individual counseling ranged from two to 22 with an average of 9.8. For treatment noncompleters (n=69): the number of sessions ranged from one to 43, with an average of eight sessions; hours of assessment ranged from one to seven with an average of 2.5; and hours of individual counseling ranged from one to 22 with an average of five.

**Table 12**

**TREATMENT INTENSITY BY DISCHARGE STATUS**

| | Treatment Completers (n=47) | | Treatment Non-completers (n=69) | |
|---|---|---|---|---|
| | **Count** | **%** | **Count** | **%** |
| **Total Number of Sessions** | | | | |
| 1-5 | 5 | 11 | 36 | 52 |
| 6-10 | 18 | 38 | 15 | 22 |
| 11-20 | 13 | 28 | 10 | 15 |
| 21-30 | 7 | 15 | 2 | 3 |
| 31-40 | 1 | 2 | 0 | 0 |
| 41+ | 1 | 2 | 2 | 3 |
| **Hours of Assessment** | | | | |
| < 2 hours | 4 | 9 | 10 | 15 |
| >= 2 hours < 3 hours | 15 | 32 | 23 | 33 |
| 3 hours | 19 | 40 | 26 | 38 |
| > 3 hours | 9 | 19 | 7 | 10 |
| **Hours of Individual Counseling** | | | | |
| < 5 | 5 | 11 | 35 | 51 |
| 5-10 | 23 | 49 | 22 | 32 |
| 11-20 | 9 | 19 | 5 | 8 |
| 21-30 | 5 | 11 | 2 | 3 |

## CLIENT RATINGS OF TREATMENT HELPFULNESS

Clients were asked at discharge to rate the helpfulness of selected treatment components on the following four-point scale: (a) much help; (b) some help; (c) little help; and (d) no help. Table 13 presents the results of these ratings by those clients who completed treatment. Not all clients received all treatment components. In fact, most clients' treatment was limited to assessment and individual counseling.

**Table 13**

**CLIENT RATINGS OF TREATMENT COMPONENT HELPFULNESS (n=42)**
**(Percent)**

| | Much Help % | Some Help % | Little Help % | No Help % | Did not Receive % |
|---|---|---|---|---|---|
| **Individual Counseling** | 88 | 10 | 0 | 0 | 2 |
| **Gambling Assessment** | 60 | 36 | 2 | 0 | 2 |
| **Group Counseling** | 33 | 10 | 2 | 0 | 55 |
| **Family Counseling** | 33 | 10 | 0 | 0 | 57 |
| **Peer Support** | 32 | 7 | 2 | 0 | 59 |
| **Financial Counseling** | 26 | 24 | 0 | 5 | 45 |
| **Homework Assignments** | 44 | 27 | 0 | 5 | 24 |
| **Orientation to GA** | 41 | 8 | 10 | 3 | 39 |

## CLIENT SATISFACTION

Table 14 presents client satisfaction information on selected items. The treatment providers were rated very highly by clients on the satisfaction items. Overall, providers received "very satisfied" ratings by 88% of the clients and "satisfied" ratings by an additional 12%. Likewise, ratings of skills/strategies to remain gambling free and overall satisfaction were high; all but one client gave either "very satisfied" or "satisfied" ratings to these items.

**Table 14**

**CLIENT SATISFACTION (N=42)**
**(Percent)**

| | Very Satisfied % | Satisfied % | Dissatisfied % | Very Dissatisfied % |
|---|---|---|---|---|
| **Your Counselor** | 88 | 12 | 0 | 0 |
| **Skills/strategies learned to remain gambling free** | 45 | 52 | 2 | 0 |
| **Overall services you received** | 78 | 20 | 2 | 0 |

## TREATMENT OUTCOME

The following section addresses the question, “Does treatment work?” i.e., “Do clients get better?” This fundamental question seems simple at first glance. However, in order to answer this “simple” question, a number of more complex questions must be addressed including, “How is treatment success defined?” and “How is change measured?” There are a variety of definitions of treatment success in the research literature (Strupp, 1993) and a variety of proposed methods for measuring change (Collins & Horn, 1991).

A common approach in addiction treatment outcome research is to use the traditional treatment goal of abstinence as the measure of success, i.e., the percent of the follow-up sample that reports no gambling during the follow-up period. This data is presented first in Table 15 and Figures 3-5. Using a dichotomous outcome criterion tied to an absolutistic treatment goal is less than optimal. This approach reports only post-treatment gambling rates and ignores pretreatment gambling levels. Furthermore, this dichotomous outcome variable is too simplistic in terms of the actual behavior of gambling following treatment. Some clients may significantly reduce their gambling compared to pretreatment levels; this reduction should not be ignored or interpreted as a treatment failure, even if it is short of complete abstinence. For example, clients may have one or more “slips,” but they use these “slips” in a positive way to learn better ways of maintaining their recovery. Given that most human behavior is best represented by a continuum, we recommend that success be defined in terms of increments of improvement over time (Stinchfield, Owen, & Winters, 1994).

Historically, treatment outcome research has been preoccupied with demonstrating statistically significant differences between pretest and posttest assessments. This traditional approach, i.e., statistically significant change, is presented next, in Tables 18-19. However, this approach fails to indicate whether the observed change is clinically significant or practically meaningful. Some changes may be statistically significant, but may not be considered clinically significant (and vice versa). This approach also tends to ignore individual patient outcomes by reporting group statistics rather than individual outcomes (Stinchfield & Winters, 1997). Group statistics indicate whether the group as a whole showed a change from pretreatment to post-treatment assessments. But the individual scores are imbedded in the group average and thus are obscured by the group statistics. Clinicians want to know whether a particular individual client got better, did not change, or got worse.

A third approach proposed by Jacobson and Truax (1991) looks at clinically significant change and is presented in Figures 9-11. Clients must demonstrate a change in behavior (i.e., test scores) where the client moves from the clinical or dysfunctional range of behavior to the normative or functional range of behavior as measured on a standardized scale. This approach allows for the examination of change in individual clients, and allows the researcher to identify who got better, who did not change, and who got worse. This type of treatment outcome methodology has the following advantages: (a) it measures change from pre-treatment to post-treatment, which is superior to reporting post-treatment abstinence rates alone (Stinchfield, Owen, & Winters, 1994); and (b) it provides outcome results for individual clients. These three approaches of presenting treatment outcome results, i.e., abstinence rates, tests of statistical significance, and clinical significance of change, will be reported in that order.

## COMPARISON OF HIGHEST LEVEL OF GAMBLING FREQUENCY AT ADMISSION, DISCHARGE, AND THREE-MONTHS FOLLOW-UP

Table 15 compares the frequency distribution of highest level of gambling frequency at admission, discharge, and three-months follow-up. Although these figures do not represent matched cases at each measurement point, the pattern of results indicates that one-third of clients were abstinent during the three-months follow-up period.

**Table 15**

**COMPARISON OF HIGHEST LEVEL OF GAMBLING FREQUENCY AT ADMISSION, DISCHARGE, AND THREE-MONTHS FOLLOW-UP**

| Outcome Variable | Admission (n=116) % | Discharge (n=43) % | 3-months Follow-up (n=26) % |
|---|---|---|---|
| **Highest level of gambling frequency** | | | |
| None | 3 | 30 | 35 |
| < Once/Month | 2 | 30 | 15 |
| 1-3 Days/Month | 17 | 26 | 19 |
| 1-2 Days/Week | 26 | 9 | 19 |
| 3-6 Days/Week | 39 | 5 | 0 |
| Daily | 13 | 0 | 12 |

**Note:** This is a longitudinal study, and some clients were not yet eligible for three-months follow-up at the time of this report.

Figures 3, 4, and 5 show a graphical representation of highest level of gambling at admission, discharge, and three-months follow-up, respectively.

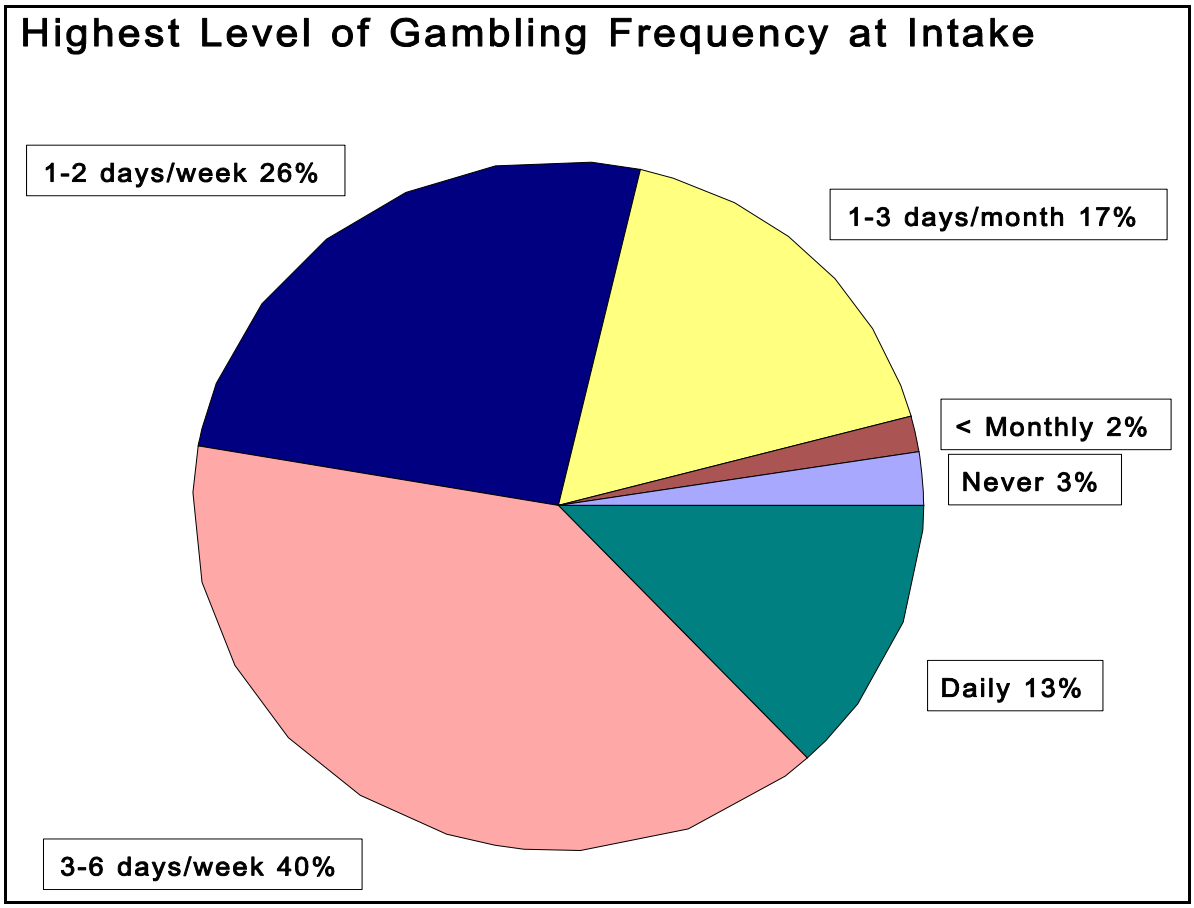


Figure 3

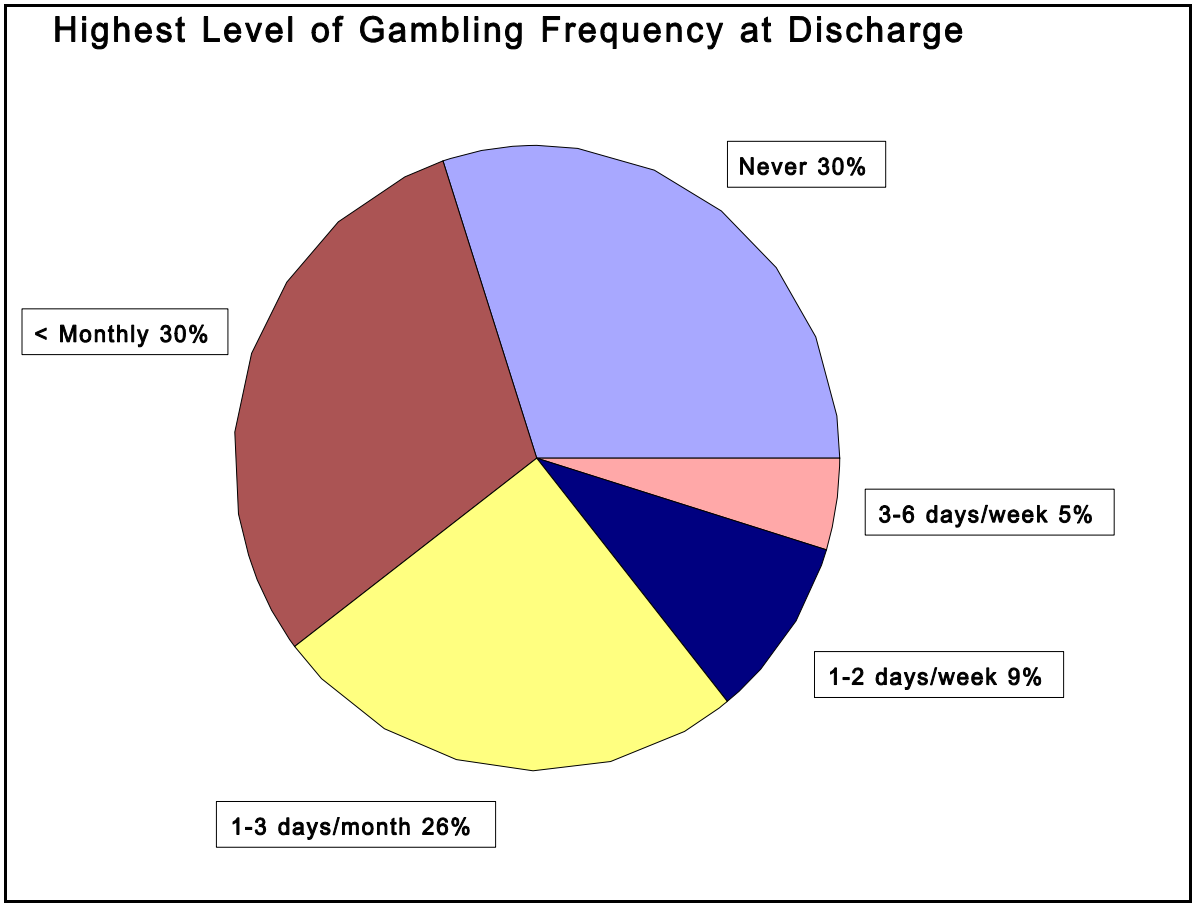
Highest Level of Gambling Frequency at Discharge
Never 30%
< Monthly 30%
3-6 days/week 5%
1-2 days/week 9%
1-3 days/month 26%

Figure 4

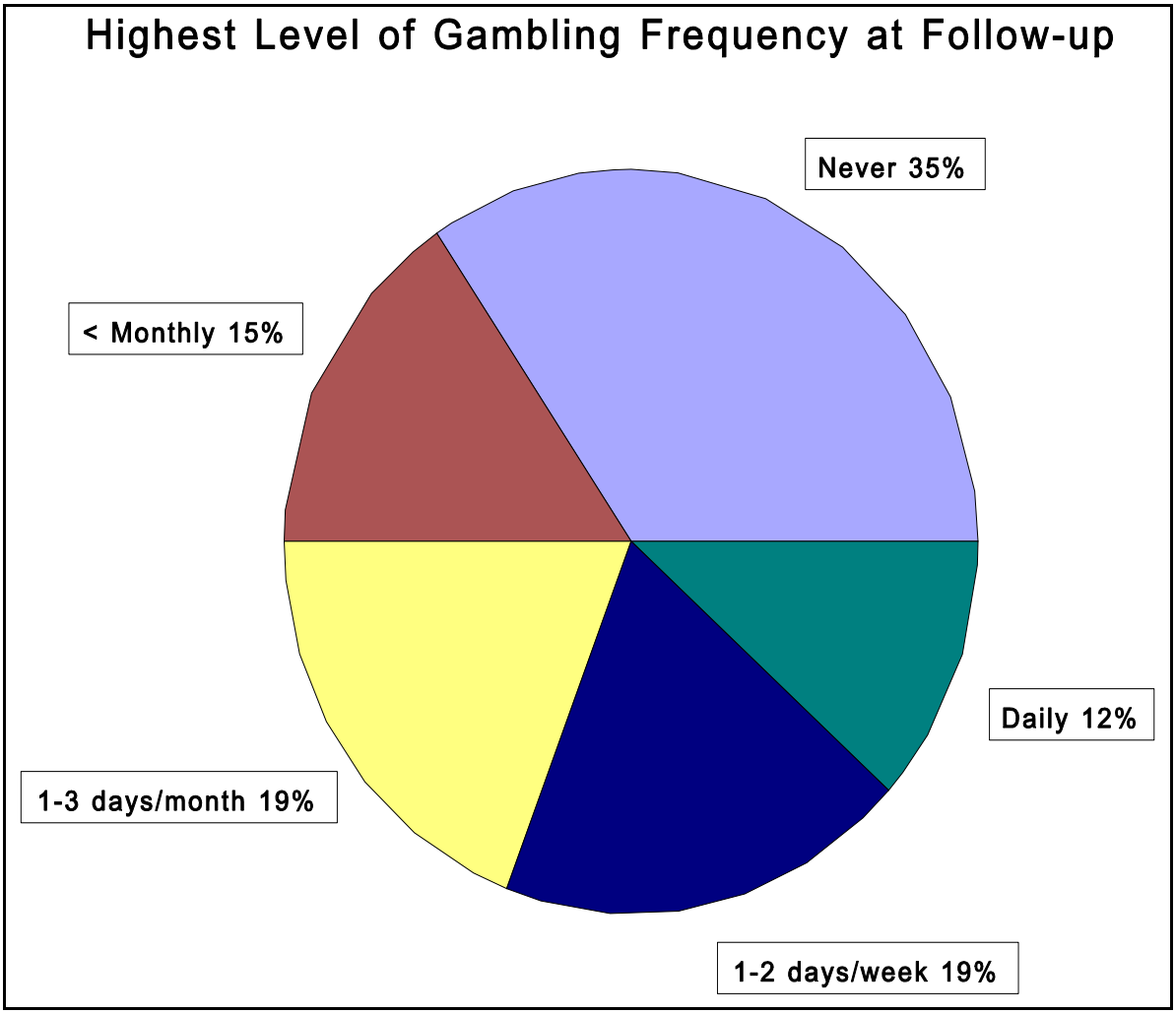
Highest Level of Gambling Frequency at Follow-up
Never 35%
< Monthly 15%
Daily 12%
1-3 days/month 19%
1-2 days/week 19%

Figure 5

## COMPARISON OF HIGHEST LEVEL OF GAMBLING FREQUENCY AT ADMISSION, DISCHARGE, AND THREE-MONTHS FOLLOW-UP

Table 16 presents a contingency table comparing highest level of gambling frequency at admission and discharge data (n=43). These results confirm the findings reported above. That is, most clients reported gambling at a weekly or daily frequency during the 12 months prior to treatment, yet the majority of them reported either no gambling or less gambling at discharge.

The difference between admission and discharge gambling frequency was further confirmed by paired t-tests. The average highest level of gambling frequency was 3.2 (sd=1.1) at admission and 1.3 (sd=1.1) at discharge. The paired t-test was statistically significant (t=9.0, p <.001, df=42). The admission average of 3.2 is equivalent to a frequency of gambling one to two days/week and the discharge average of 1.3 is equivalent to a frequency of < monthly.

Table 17 shows the comparison of highest level of gambling at admission to three-months follow-up (n=26). Again, most of the clients indicated weekly or daily gambling during the six months prior to treatment and the majority of them reported either no gambling or less gambling at three-month follow-up. A paired t-test likewise indicated statistical significance between the admission and three-month follow-up data indicated an average gambling frequency of 3.8 (sd=1.1) at admission and 1.7 (sd=1.7) at three-month follow-up, t=6.8, p <.001, df=25.

**Table 16**

**CONTINGENCY TABLE COMPARING ADMISSION TO DISCHARGE HIGHEST LEVEL OF GAMBLING FREQUENCY**

| | Discharge | | | | | | Row |
|---|---|---|---|---|---|---|---|
| **Admission** | **None** | **< once /Month** | **1-3 days /Month** | **1-2 days /Week** | **3-6 days /Week** | **Daily** | **Totals** |
| **None** | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| **< once /Month** | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| **1-3 days /Month** | 3 | 5 | 2 | 0 | 1 | 0 | 11 |
| **1-2 days /Week** | 4 | 2 | 3 | 2 | 0 | 0 | 11 |
| **3-6 days /Week** | 3 | 6 | 5 | 1 | 0 | 0 | 15 |
| **Daily** | 1 | 0 | 1 | 1 | 1 | 0 | 4 |
| **Column Totals** | 13 | 13 | 11 | 4 | 2 | 0 | 43 |

**Table 17**

**CONTINGENCY TABLE COMPARING ADMISSION TO THREE-MONTHS FOLLOW-UP HIGHEST LEVEL OF GAMBLING FREQUENCY**

| | Three-Months Follow-up | | | | | | Row |
|---|---|---|---|---|---|---|---|
| **Admission** | **None** | **< once /Month** | **1-3 days /Month** | **1-2 days /Week** | **3-6 days /Week** | **Daily** | **Totals** |
| **None** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **< once /Month** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **1-3 days /Month** | 3 | 0 | 0 | 1 | 0 | 0 | 4 |
| **1-2 days /Week** | 2 | 0 | 1 | 2 | 0 | 0 | 5 |
| **3-6 days /Week** | 3 | 3 | 2 | 1 | 0 | 0 | 9 |
| **Daily** | 1 | 1 | 2 | 1 | 0 | 3 | 8 |
| **Column Totals** | 9 | 4 | 5 | 5 | 0 | 3 | 26 |

## COMPARISON OF HIGHEST LEVEL OF GAMBLING AT ADMISSION, DISCHARGE, AND THREE-MONTHS FOLLOW-UP

Figure 6 shows a line chart of the average highest level of gambling at admission, discharge, and three-months follow-up (n=11). The numbers on the vertical axis are defined as: 0=none, 1=less than once/month, 2=1-3 days/month, 3=1-2 days/week, 4=3-6 days/week, and 5=daily. A multivariate analysis of variance (MANOVA) with repeated measures was applied to the 11 clients who had data at admission, discharge, and three-months follow-up. The average highest level of gambling frequency at admission was 3.7 (sd=1.1), at discharge 1.5 (sd=1.3), and at three-months follow-up 1.2 (sd=1.7). The MANOVA was statistically significant for the effect of time ($F=6.5$, $p<.001$, $df=2,9$). That is, the discharge and three-months follow-up highest level of gambling were significantly lower than pretreatment highest level of gambling. There was a statistically significant decline in gambling frequency from an average of gambling a number of days per week before treatment to an average of less than once per month at discharge and at three-months follow-up.

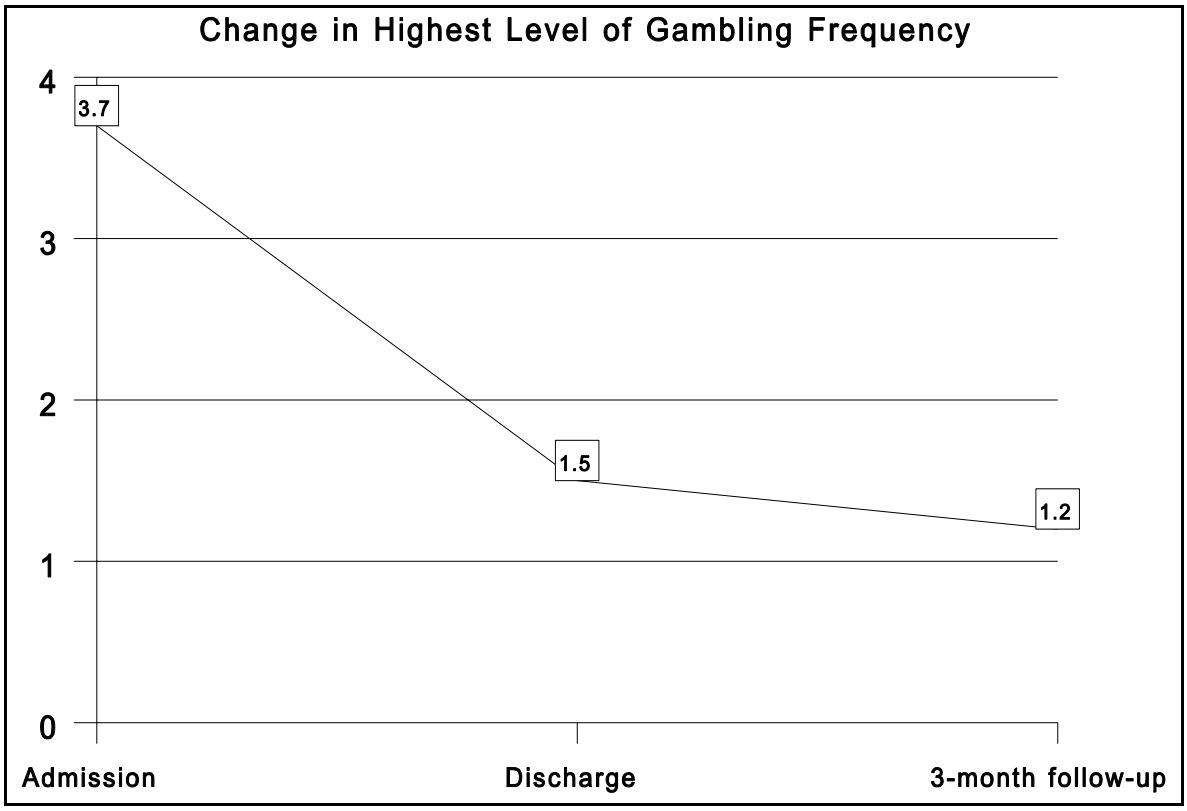


Figure 6

## COMPARISON OF SOGS SCORES AT ADMISSION AND THREE-MONTHS FOLLOW-UP

Figure 7 shows a line chart of the average SOGS score at admission and three-months follow-up. The SOGS score range is from zero to 20, with a score of five or greater indicating that the individual is a "probable pathological gambler."

A paired t-test was applied to the 23 clients who had SOGS data at both admission and three-months follow-up. The average SOGS score at admission was 13.4 (sd=3.4) and 6.3 (sd=4.7) at three-months follow-up. The t-test was statistically significant (t=7.2, p <.001, df=24). The three-months follow-up SOGS scores were significantly lower than the admission or pretreatment level of gambling.

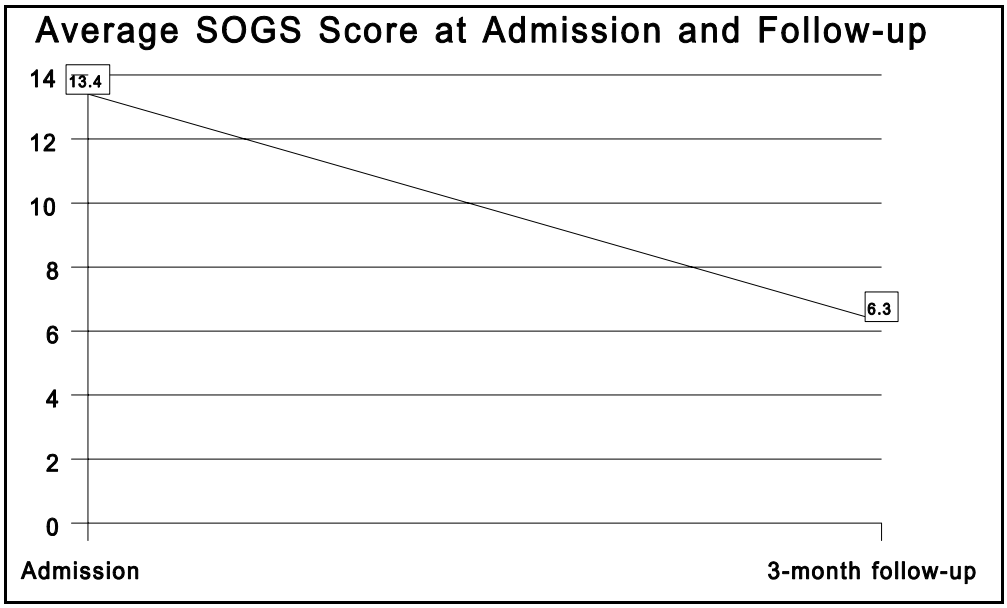


Figure 7

## COMPARISON OF DSM-IV SCORES AT ADMISSION AND THREE-MONTHS FOLLOW-UP

Figure 8 shows a line chart of the average DSM-IV score at admission and three-months follow-up. The DSM-IV score range is from zero to ten, with a score of five or greater indicating that the individual is a pathological gambler.

A paired t-test was applied to the 29 clients who had DSM-IV data at admission and three-months follow-up. The average DSM-IV score at admission was 8.2 (sd=1.8) and 3.1 (sd=2.8) at three-months follow-up. The t-test was statistically significant ($t=8.7$, $p < .001$, $df=28$). The three-months follow-up DSM-IV scores were significantly lower than the admission or pre-treatment level of gambling.

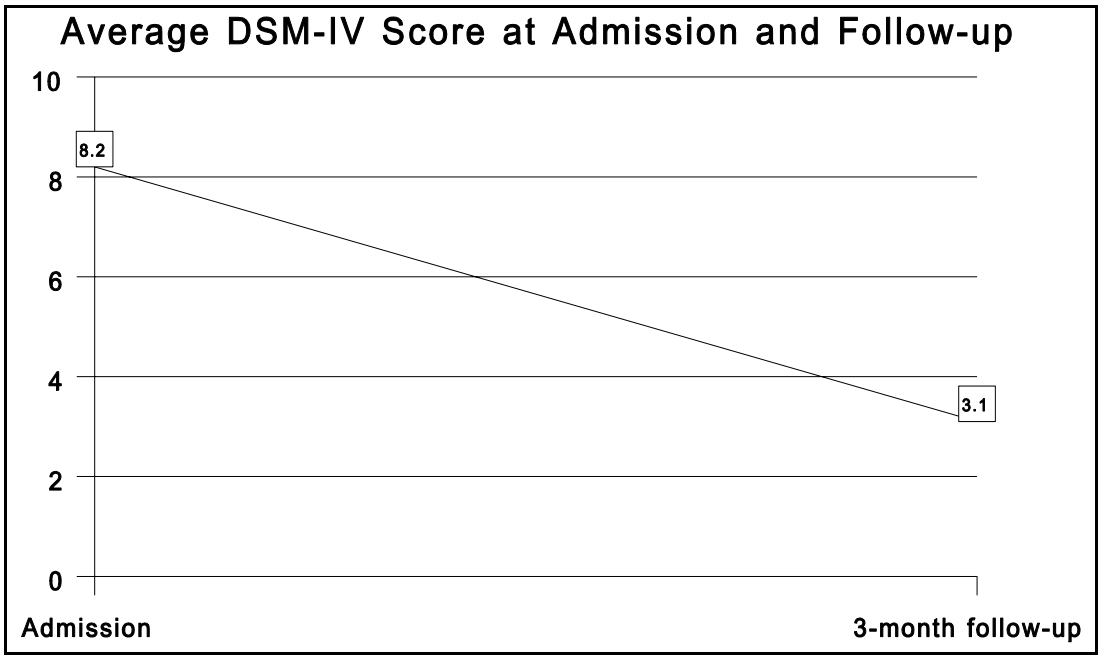


Figure 8

## COMPARISON OF GAMBLING PROBLEM SEVERITY MEASURES BETWEEN ADMISSION AND THREE-MONTHS FOLLOW-UP

Table 18 presents the comparison of admission to three-months follow-up data on a number of outcome variables for which both measurement points were available. On all of these outcome measures, the lower score means more favorable functioning. Significant change in the improved direction was found for the following variables: highest level of gambling, SOGS, DSM-IV, financial problems, days of conflict with family, and illegal behavior.

**Table 18**

**COMPARISON OF ADMISSION TO THREE-MONTHS FOLLOW-UP OUTCOME (n=31)**

| Outcome variable | Admission | | 3-months Follow-up | | | |
|---|---|---|---|---|---|---|
| | M | SD | M | SD | t | p |
| **Highest level of gambling**[1] | 3.8 | 1.1 | 1.7 | 1.7 | 6.8 | <.001 |
| **SOGS** | 13.4 | 3.4 | 6.3 | 4.7 | 7.2 | <.001 |
| **DSM-IV** | 8.2 | 1.8 | 3.1 | 2.8 | 8.7 | <.001 |
| **Financial Problems** | 10.2 | 5.2 | 2.0 | 3.0 | 7.9 | <.001 |
| **Days of conflict with family** | 3.5 | 5.5 | 0.8 | 1.1 | 2.6 | .016 |
| **Illegal Behavior** | 1.0 | 1.2 | 0.1 | 0.3 | 4.2 | <.001 |

M=mean or average.
SD=standard deviation.
t=t-test value.
p = statistical significance level
[1] 0=none, 1=< once/month, 2=1-3 days/month, 3=1-2 days/week, 4=3-6 days/week, 5=daily.

## COMPARISON OF BASIS-32 SCALES BETWEEN ADMISSION AND DISCHARGE

Table 19 presents the comparison of admission to discharge data on BASIS-32 mental health outcome scales. The lower the BASIS-32 scores the more favorable the client's functioning. Significant change in the improved direction was found for all of the BASIS-32 scales from pre-treatment to discharge at the alpha=.05 level. These results show improvement in mental health functioning from pre-treatment to post-treatment.

**Table 19**

**COMPARISON OF BASIS-32 SCALES FROM ADMISSION TO DISCHARGE (n=41)**

| | Admission | | Discharge | | | |
|---|---|---|---|---|---|---|
| **Outcome variable** | **M** | **SD** | **M** | **SD** | **t** | **p** |
| **Relation to Self/Others** | 2.8 | 1.1 | 2.1 | 0.9 | 4.6 | <.001 |
| **Depression/Anxiety** | 2.7 | 1.0 | 2.0 | 1.0 | 3.7 | .001 |
| **Daily Living Skills** | 2.7 | 1.0 | 2.0 | 0.9 | 4.3 | <.001 |
| **Impulsive/Addictive Behavior** | 1.6 | 0.7 | 1.4 | 0.4 | 2.3 | .024 |
| **Psychosis** | 1.4 | 0.5 | 1.2 | 0.4 | 2.2 | .031 |
| **Overall** | 2.3 | 0.8 | 1.8 | 0.7 | 4.1 | <.001 |

M=mean or average.
SD=standard deviation.
t=t-test value.
p = significance level

## CLINICALLY SIGNIFICANT CHANGE

The third approach to measuring treatment outcome is to examine clinically significant change. A change in a client's score is considered clinically significant if the change represents a movement out of the clinical or dysfunctional range of behavior into the normative or functional range of behavior. This approach answers the questions: who got better, who did not change, and who got worse.

Two critical variables for measuring pathological gambling treatment success are gambling frequency and gambling problem severity (i.e., negative consequences of gambling and signs and symptoms). Therefore, the approach of measuring clinically significant change was applied to the measures of gambling frequency and gambling problem severity (i.e., SOGS and DSM-IV scores). For assessing clinical significance of change, Jacobson and Truax (1991) recommend using a cut score that provides optimal discrimination between functional and dysfunctional groups. The SOGS has a standard cut score of five or higher to identify probable pathological gamblers (Lesieur & Blume, 1987; Stinchfield, 2002). DSM-IV also has a standard cut score of five to indicate Pathological Gambling (American Psychiatric Association, 1994; Stinchfield, 2003). The gambling frequency cut score that best discriminates a general population sample from a clinical sample is monthly or less frequent gambling versus weekly or more frequent gambling (Stinchfield & Winters, 2001).

**Gambling Frequency**

Gambling frequency is measured on a six-point scale: (1) never; (2) less than once/month; (3) 1-3 days/month; (4) 1-2 days/week, (5) 3-6 days/week; and (6) daily. In terms of clinically significant change, a client has to move from being a weekly or daily gambler to a monthly or less frequent gambler after treatment. Figure 9 shows a pie chart of the distribution of clinically significant change on gambling frequency between intake and three-months follow-up. The majority of clients (58%) moved from the clinical to the normative range, 27% stayed in the clinical range at both assessments, 12% stayed in the normative range at both assessments, and one client (4%) moved from the normative to the clinical range.

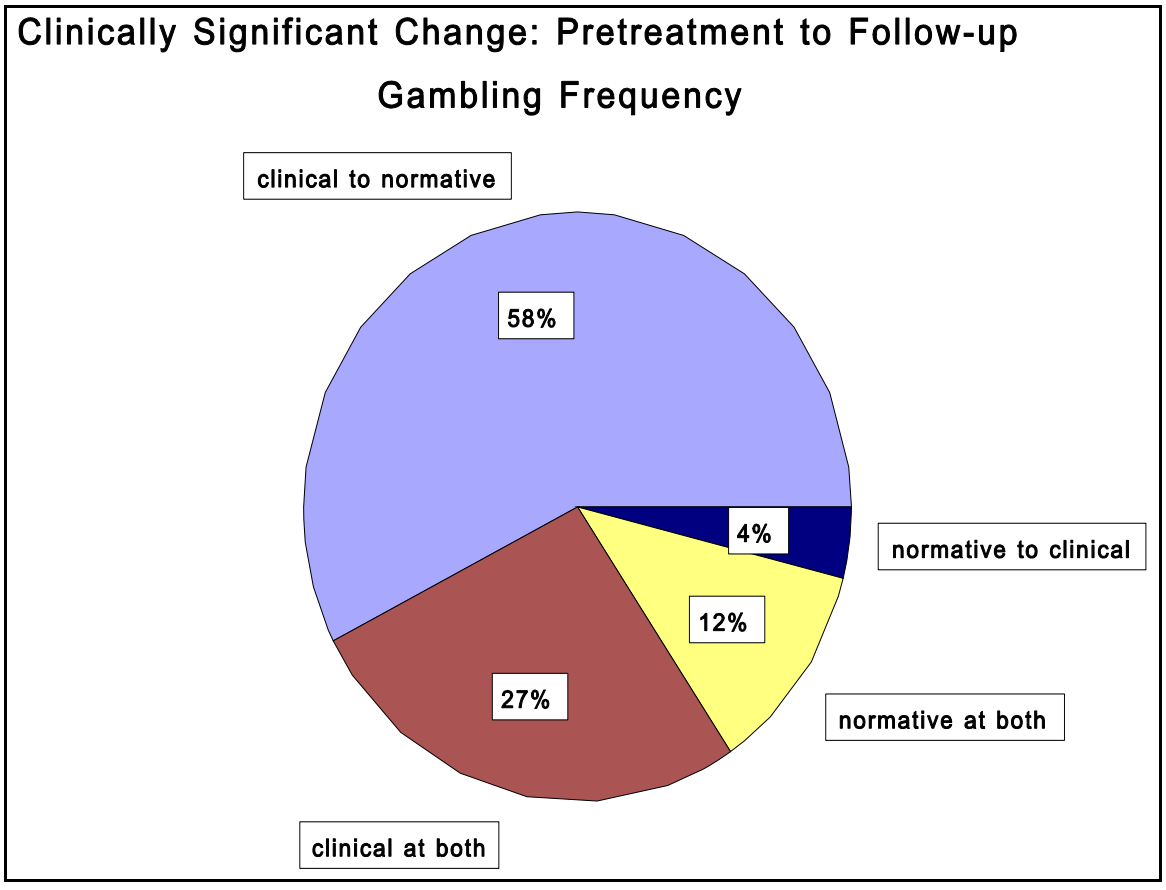


Figure 9

**Gambling Problem Severity (SOGS)**

In terms of clinically significant change, a client would have to move from a SOGS score of five or higher to a SOGS score of less than five after treatment. Figure 10 shows a pie chart of the distribution of clinically significant change on SOGS scores between intake and three-months follow-up. Over one-third (36%) of the sample moved from the clinical to the normative range, 60% stayed in the clinical range at both intake and follow-up, and one client (4%) stayed in the normative range at both assessments.

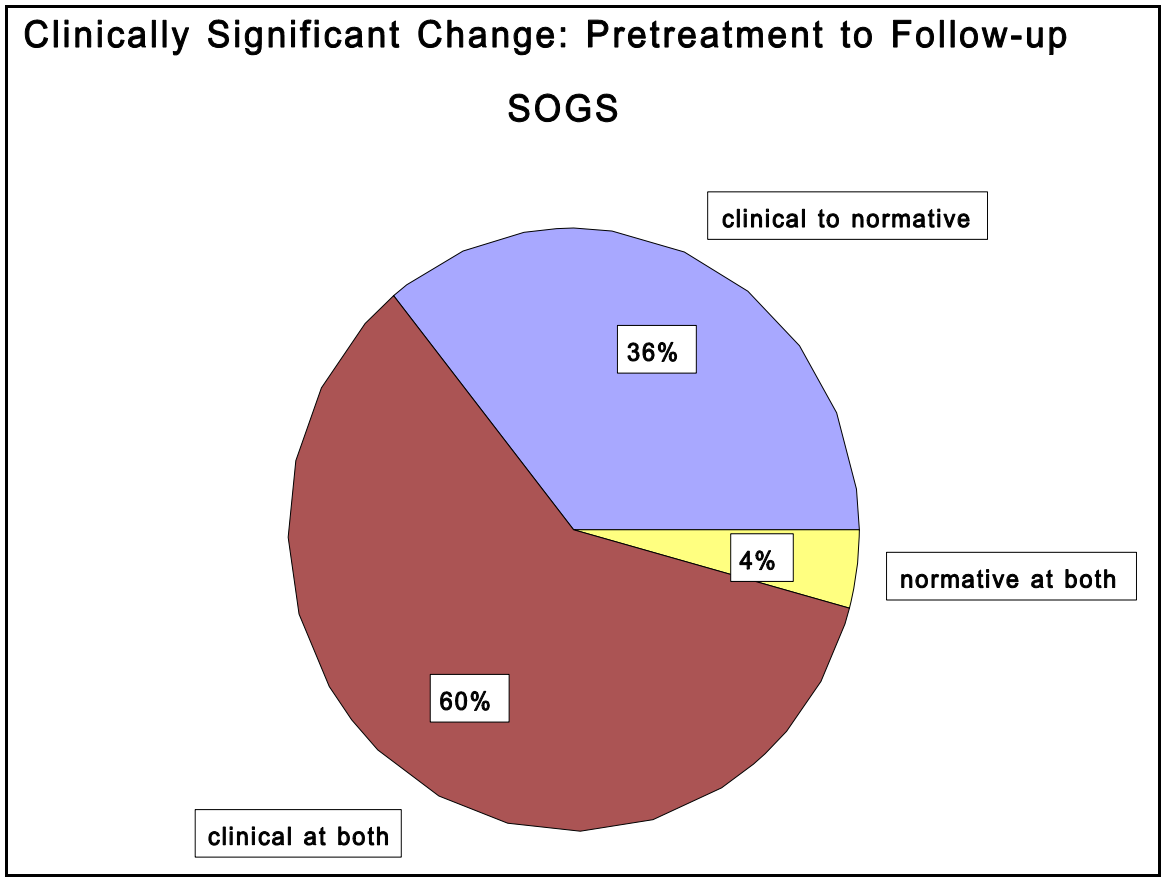


Figure 10

**Gambling Problem Severity (DSM-IV)**

In terms of clinically significant change, a client would have to move from a SOGS score of five or higher to a SOGS score of less than five after treatment. Figure 11 shows a pie chart of the distribution of clinically significant change on SOGS scores between intake and three-months follow-up. The majority of clients (55%) moved from the clinical to the normative range, 41% stayed in the clinical range at both intake and follow-up, and one client (4%) stayed in the normative range at both assessments.

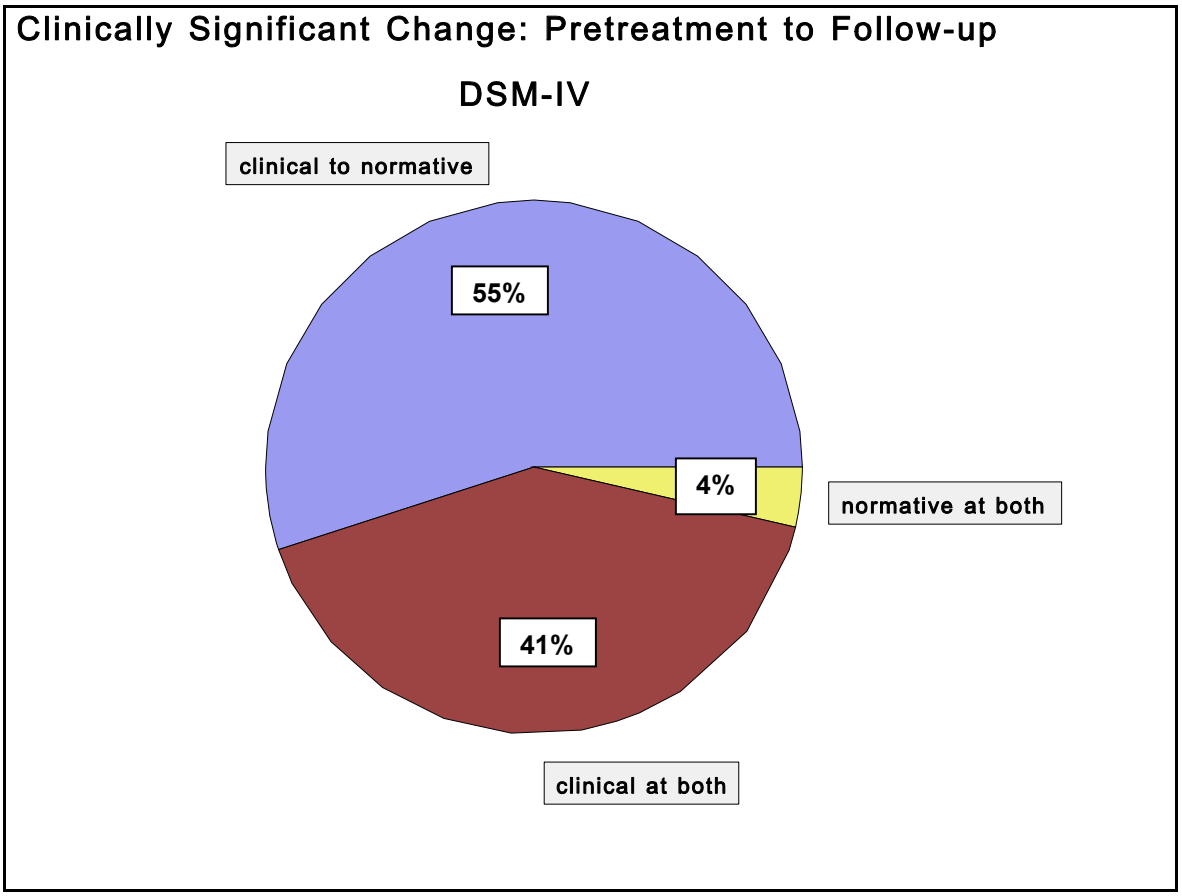


Figure 11

## POST-TREATMENT SERVICE UTILIZATION AND RECOVERY ACTIVITIES

Table 20 presents the extent to which clients utilized various post-treatment services and engaged in various recovery activities. Participation in post-treatment recovery services has been shown in previous research to be related to improved outcomes. Clients used many types of post-treatment services, yet post-treatment services utilization rates were quite low. The most commonly used post-treatment service was Gamblers Anonymous (GA) and that was only used by one-third of the sample. Furthermore, fewer still, reported that they have a GA sponsor or they have completed the 12th step of their GA program.

**Table 20**

**POST-TREATMENT SERVICE UTILIZATION AND BEHAVIOR**

| | 3-month (n=33) | |
|---|---|---|
| **Type of Service/Behavior** | **Count** | **%** |
| **Aftercare/Extended Care** | 4 | 12 |
| **Gamblers Anonymous** | 12 | 36 |
| **Alcoholics/Narcotics Anonymous** | 5 | 15 |
| **Other 12-Step** | 1 | 3 |
| **Alcohol/Drug Abuse Treatment** | 2 | 6 |
| **Mental Health Treatment** | 5 | 16 |
| **Financial Counseling** | 1 | 3 |
| **Vocational Counseling** | 3 | 9 |
| **Marital Counseling** | 2 | 7 |
| **Other Support Group or Counseling or Service** | 2 | 7 |
| **Has a GA Sponsor** | 6 | 18 |
| **Completed 12th Step in GA** | 2 | 7 |
| **Sponsored another GA member** | 2 | 7 |

## SUMMARY OF STUDY FINDINGS

The study was designed to address seven research questions. Each question will be examined and discussed.

*(1) What are the demographic characteristics and clinical history of gamblers seeking treatment?*

The typical client is a white middle-aged (average age of 43) person who is equally likely to be male or female and who is equally likely to be single, married or divorced. She has graduated from high school and has some college education. He has a moderately skilled occupation and works full-time, and makes less than $30,000/year. She has come to treatment primarily as a result of her own decision to get help. He has sought help for his/her gambling problem before coming to treatment and has often participated in GA. She is likely to have been through substance abuse and/or mental health treatment. He began to gamble before age 21 and his preferred game is either cards, such as blackjack and poker, or gambling machines, such as slots or VLTs. She has lost between $1,000 and $5,000 in a single day of gambling. Prior to treatment he gambled almost every day. She has accrued a gambling-debt of $30,000. He is indebted to creditors, such as banks, credit cards, loan companies, etc. She has borrowed money from family and has borrowed against his checking account and has written bad checks but has not been arrested. He has also sold stocks and cashed in life insurance policies to cover his gambling debts. She has skipped out of work to gamble. He is a daily smoker and drinks occasionally.

*(2) What is the level of severity of the client's gambling problem at admission?*

Over 90% of the clients presenting themselves for treatment obtained scores on the SOGS and DSM-IV over the clinical threshold of five or more for both measures. The average SOGS score was 13 and the average DSM-IV score was eight. This represents serious problem severity and few clients were below or even at the cut score of five. Almost one-half (44%) of the samples reported a current gambling debt of at least $10,000, with 4% reporting debt in excess of $100,000. The average gambling-related debt was $30,000 with a median of $10,000.

*(3) What treatment components do clients rate as helpful?*

Clients found most of the treatment components to be helpful in their recovery. Clients gave the highest helpfulness ratings to individual counseling, homework assignments and orientation to GA.

*(4) Are clients satisfied with their treatment?*

The answer to this question is “Yes.” All, but one client, were “very satisfied” or “satisfied” with their counselor and the treatment services they received.

*(5) Do clients abstain from or reduce gambling involvement during the course of outpatient treatment and at follow-up?*

Most clients gambled very little, if at all, during the course of outpatient treatment. At three-months follow-up, one-third of the sample was abstinent and another third had gambled less than once per week. There was a statistically significant decline in gambling frequency from an average of gambling a number of days per week before treatment to an average of less than once per month at discharge and at three-months follow-up. In terms of clinically significant change on gambling frequency, over half of the sample moved from the clinical range to the normative range between admission and three-months follow-up. SOGS scores declined significantly, from an average of 13 at admission to an average of six at three-months follow-up. DSM-IV scores declined significantly from an average of eight at admission to an average of three at three-months follow-up. Financial problems decreased from an average of ten at admission to an average of two at three-months follow-up. Illegal behavior decreased from an average of one at admission to zero at three-months follow-up. It should be noted that most of these clients did not complete treatment and many still showed a significant reduction in gambling and gambling-related problems.

*(6) Do clients function better in the areas of social and vocational responsibilities following treatment?*

The number of days of conflict with family members decreased from an average of three at admission to an average of one at three-months follow-up. Mental health functioning improved from admission to discharge as demonstrated by statistically significant improvements on the BASIS-32 scales of Relation to Self/Others, Depression/Anxiety, Daily Living Skills, Impulsive/Addictive Behavior, Psychosis, and the overall BASIS-32 scale.

*(7) Do clients participate in post-treatment recovery services (e.g., aftercare and GA meetings)?*

Participation rates in post-treatment recovery services were low. Only one-third of the sample participated in Gamblers Anonymous and even lower rates (10%) were observed for other services such as aftercare or extended care. Addiction experts agree that it is relatively easy to get clients to stop their addictive behavior, but it is much more difficult to keep them from going back to their addictive behavior after treatment and this is why participation in post-treatment recovery services is so important.

These outcome results are similar to results obtained from other gambling treatment outcome studies (e.g., Stinchfield & Winters, 2001). Many, but clearly not all, clients reported abstinence from gambling and showed improved functioning after treatment. On the other hand, some clients were still gambling at follow-up and had not improved significantly compared to intake levels of functioning. This somewhat mixed outcome picture is understandable in light of the fact that pathological gambling appears to be as chronic a condition as alcoholism and drug addiction. The descriptive data indicate that pathological gamblers often suffer from other mental disorders, including alcoholism, and

experience a host of psychosocial and environmental stressors. Furthermore, gambling treatment, which is modeled after the traditions of substance abuse treatment, is still relatively new. As the treatment field matures and research progresses, the opportunities will increase for improving upon current treatment outcomes.

## LIMITATIONS AND RECOMMENDATIONS

### *SMALL SAMPLE SIZE AT DISCHARGE AND FOLLOW-UP*

Due to the short time frame for the study, it was difficult to obtain data at discharge and follow-up after following them through the course of treatment. Many clients had not reached their three-month follow-up anniversary at the time the data needed to be analyzed. The small sample sizes at discharge and follow-up raise questions about the generalizability of the findings. Can these results from 30 cases be generalized to the rest of the sample? At this point, the data should be interpreted with caution, until a larger sample size can be obtained. The reader needs to keep in mind that small sample sizes run the risk of being influenced by outliers, i.e., one or two cases with aberrant data can have an impact on the group statistic and can sway the average one way or the other. If these 30 cases are a random sample of the larger intake sample and there is no bias in the selection of these 30 cases, we can have some confidence that these results are representative of the larger sample.

### *ATTRITION AND FOLLOW-UP CONTACT BIAS*

It should be noted that not all clients have complete data sets. Although these data collection rates are respectable, this still leaves some clients unaccounted for at discharge and follow-up. The outcome of these missing cases is unknown. The success rate of the located sample may not be generalizable to the unlocated sample. Without knowledge of the outcome of this unlocated sample and a reasonable probability that some of them may not be doing as well as the located sample, the success rates reported here may be attenuated.

There is no consensus among researchers as to whether the noncontacted sample should be included or excluded from the statistical analysis of treatment outcome results (Beutler, 1990; Emrick and Hansen, 1983). Some investigators report all noncontacted subjects as treatment failures (Nathan and Lansky, 1978; Sobell, 1978). That is, if a client cannot be contacted to provide information about their outcome status, this client must be counted as a treatment failure. In contrast, other researchers exclude noncontacted subjects from the analysis and acknowledge the potential effect of this exclusion on the outcome results (Harrison and Hoffmann, 1989; Keskinen, 1986). A study conducted by the author with adolescent drug abusers showed that the hard-to-contact sample, as a group, had poorer outcomes than the easy-to-contact sample, however, not all of the hard-to-contact clients were treatment failures, as is often presumed, and some had very good outcomes (Stinchfield, Niforopulos, & Feder, 1994). Therefore, it is probably safe to assume that those clients who could not be located at three-months follow-up, as a group, are likely to have poorer outcomes than the contacted group, however, it cannot be assumed that they are all treatment failures.

*CAUSAL INFERENCE*

Although we would like to infer that treatment caused the changes in clients, the lack of a no treatment control group precludes making such an inference with complete confidence. For example, it is unknown what would have happened to the clients if they had not gone through treatment. However, the results of the study **suggest** that the treatment was influential in the improvement of clients. The ideal treatment effectiveness research design would include random assignment of some clients to a no-treatment control group, however, ethical concerns regarding the withholding of treatment precludes the use of this design.

*VALIDITY OF SELF-REPORT*

The majority of data in this report comes from self-report. While there is no way of independently verifying the accuracy of this self-reported data, study procedures were implemented to facilitate the validity of self-report, e.g., client names were not used on questionnaires and clients were assured of the confidentiality of their responses. Furthermore, previous research in this field has suggested that self-report data is, for the most part, fairly accurate, particularly when efforts are implemented to facilitate its accuracy of self-report (Stinchfield & Winters, 2001).

*IMPROVING TREATMENT*

The 19 gambling treatment providers achieved respectable outcome results that are similar to those reported for gambling treatment (Stinchfield & Winters, 2001). However, this evaluation also identified a number of areas, which leave room for improvement. First, adult prevalence survey results suggest that there may be more pathological gamblers in the community than are coming to treatment. Therefore, one area for improvement is the identification of those individuals who are pathological gamblers and the referral to treatment services. One way to achieve this goal is public awareness and particularly the training and encouragement of mental health professionals to screen for pathological gambling. Another is to increase general public awareness of the availability of screening and treatment services.

Second, a large number of clients did not complete treatment. Therefore, treatment providers need to identify the causes of treatment noncompletion to determine if retention rates can be improved. Finally, although these treatment providers achieved substantial success rates, there is still room for improving these rates. Future research needs to evaluate strategies developed to improve screening, referral, client retention in treatment programs, and client outcomes.

Third, there were relatively low participation rates in post-treatment recovery services. Only one-third participated in GA and less than that participated in other post-treatment services. It is important that clients have continuing care of some sort following primary treatment. It will be important to develop a continuum of care and provide post-treatment services and provide referral and links to these services. Addiction experts agree that the most important time in a person's recovery is the period right after treatment and what happens during this period will influence the individual's long-term recovery.

*FUTURE RESEARCH DIRECTIONS*

The current study measures client behaviors before treatment and after treatment, but it does not measure what happens in treatment (i.e., therapeutic approach, types and amounts of treatment services, etc). Therefore, future research will need to address and measure what happens in treatment. Then, this information can be used to look for associations between what happens within treatment and client outcomes. It will also be important for future research to analyze the cost-benefit ratio of treatment. That is, what benefits are obtained by providing treatment and are the benefits worth the cost of treatment.

This study also sheds some light on the issue of treatment length and outcome. Even though many clients did not complete the full course of treatment, they still exhibited improvement at follow-up. Future analyses should focus on: (a) pinpointing the extent to which level of treatment intensity can produce optimal outcomes; (b) determining if there are any client subtypes that are more or less likely to respond to less intensive care; and (c) determine if we can predict which clients will leave treatment early. A related issue is that some clients may have left treatment early (and others may not have entered treatment at all) due to a poor match between the client and the treatment approach.

Some clients met criteria for treatment but either did not start treatment or dropped out of treatment before completion. It will be important to follow these clients who dropped out to determine the natural history of untreated pathological gambling and to compare the treated group to the no-treatment group. It would also be helpful to know the treatment effectiveness of individuals who are treated by non-state funded practitioners. This would provide a comparison group by which to judge the effectiveness of the state-supported gambling treatment programs. Finally, it would be important to use a standardized diagnostic assessment to obtain reliable information about the co-morbidity of other psychiatric disorders within this population, which has implications for both treatment planning and treatment outcome. These issues will need to be explored in future research.

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# Appendix To The Report

# Problem Gambling Treatment Program

# Client/Provider Testimonials

## TESTIMONIAL FROM A CLIENT

October 1, 2003

Gary,

I want to take just a minute to share some thoughts with you regarding my experience in the recently concluded problem gambling treatment program.

As you are well aware, I am in fact a pathological gambler with a relatively brief gambling experience, which started in October 1999 and concluded with my last bet on June 20, 2003. During that time, my gambling losses exceeded $200,000. I also lost my job, seriously contemplated suicide and nearly lost my home and family. In fact, I am, even yet, legally separated from my wife.

These facts not withstanding, what I have to share with you is a story of success and triumph.

In April 2001, I began receiving professional counseling in an outpatient treatment program for my gambling. I appreciate very much the sincere investment the counseling staff made in my well being. However, that program did not deal with gambling directly. As a result, I learned a great deal about my need to stop gambling and in fact, made strides in curtailing my gambling, but was unable to actually abstain. Subsequent gambling binges proved devastating and eventually cost me my 28 year career with a major company in the Puget Sound area.

Not until May 2003, when I voluntarily called the 1-800-547-6133 number and was referred to Donna Whitmire, one of the 24 counselors your organization had trained specifically to support the treatment program, did I receive professional counseling specific to my gambling addiction. In fact, I mark that first counseling session as the most significant moment in my recovery.

The help I received in that professional environment has been instrumental in, of first order, stopping all gambling, and secondly, my abstinence. Of equal significance is the impact that counseling had on my ability to return to work.

In April 2003, as a result of my gambling, I entered the ranks of the unemployed for the first time since high school. In fact, in over thirty years in the marketplace, I had never before collected unemployment insurance benefits. The cost of unemployment has been felt by me personally, my family, the state, and certainly by my former employer who lost a 28 year employee. I venture to suggest that the cost of my gambling felt by the company is even greater that the four months of unemployment I collected from the state. Replacing years of experience comes at a cost greater than simply monetary.

I credit the problem gambling treatment program with my ability to, on 26 August 2003, secure employment in a seriously depressed market. I take pride in the fact that I have

gone from being a drain on the state's resources to being productive and a contributor to the overall fiscal health of the state.

It's hard for me to adequately express my feelings regarding the problem gambling treatment program, but as succinctly as I can, let me say that the professional counseling I received at the problem gambling treatment program had indeed turned my life around. It has had a quantifiable impact on mending family relationships, pursuing a mentally and physically healthy lifestyle and my ability to recover from bankruptcy.

All that said I have one more thought for you. In my opinion, as long as the state of Washington participates in putting a gambling product of any kind in the hands of its residents, the state has an obligation to provide for problem gamblers like myself. Only through the problem gambling treatment program was I able to arrest my addiction and I am only one of a few thousand Washington residents who suffer from this same addiction. From a purely fiscal perspective, it is clear to me that the differential in cost between me collecting $496 every week in unemployment from the state coffers and paying taxes commensurate with a salary well over $150,000 per year more than compensates for the cost of the problem gambling treatment program.

Sincerely,

Eli

## TESTIMONIAL FROM A CLIENT

April 9, 2003

Dear Mr. Gary Hanson,

In 1992 I started gambling. First I played poker in a local card room. Then I started playing in different card rooms around the state. I went to La Center, Seattle, and Tacoma. I could not loose. I bought and paid cash for a 1992 Pontiac Firebird. My poker-winning streak came to an end when I started losing.

Then I started playing slot machines. I went to Wild Horse Casino and on the third spin I won $1,200. I continued playing the slots ever since. I went to Muckleshoot Casino in Auburn and lost. I went to Emerald Queen and lost. The more I lost the more I wanted to go back and play. I was always making excuses to go and thought I would win back my loses. At first I played on Friday nights. Then it progressed to at least five or six nights a week. I would drive to Legends Casino in Toppenish and drive home because they closed at 4:00 in the morning. By the time they opened back up in the morning I would be waiting in the parking lot for the doors to open. I started lying where I was and what I was doing. I would lie to borrow money to get back on the machines.

Every Friday I knew my husband's check was automatically deposited in our bank account. He would leave for work and I would spend his whole check on the machines or buying lottery tickets and scratch tickets. I kept losing.

In November of 1999 I found my son's social security number so I got credit cards in his name, as mine were all maxed to the hilt. One day my daughter-in-law came over and left her purse. I then got her social security number and got more credit cards to gamble on in her name. My son was receiving calls about no payments on his credit cards. He came and talked to me and I told him I did it. Now his credit was ruined as well as mine. I continued to gamble. I would not come home for three or four days in a row. My life became a slot machine. All the cute little pictures or numbers on the machined started to become a vision that I had in my mind constantly.

I had four friends and we would borrow money back and forth to stay and play. This became my whole life. I could not stop.

I went to three GA [Gamblers Anonymous] meetings in Yakima. On the third meeting I went into a restaurant to eat and the leader of GA was playing poker. I lost all hope. At this [time] there weren't any GA meetings in the Tri Cities.

My husband filed for divorce and I became homeless. For two weeks I slept in a large hole in the ground at a local park. No water to take a shower, no money for gas or food. I was down to nothing.

On Thanksgiving morning of 2002 I was arrested and put in Benton County Jail for Identity Theft. My son, his wife, and a friend pressed charges on the credit cards I used in 1999. I would tell them, "Oh, I'll win and pay them off." It never happened.

After getting out of jail I went to a counselor at Sunderland Clinic. My court appointed attorney called me at 7:00 p.m. on Monday – (President's Day). I was to go to court on Wednesday the 19th. She told me I was going to plead guilty and would go back into Benton County Jail and then to Purdy (the Women's Correctional Center). While in Benton County, in early December, I went into a diabetic shock and almost died. None of the guards were around. The women in my pod started yelling and screaming they got the woman from the next pod doing the same trying desperately to get help. One of the women in the next pod saw all the guards outside smoking and talking. This happened around 7:45 p.m. A gal in our pod said the guards were gone for 38 minutes.

I got out of jail in a nightgown with pouring rain. I walked around and felt so low I wanted to commit suicide.

I found a phone number through the state and called. I told them I desperately needed help now.

I went to visit Dr. Richard Cornish. The day before I still wanted to commit suicide. He was the most understanding person I have ever met. He made me feel like a person who needed help and I certainly did. Slowly I am getting better. He has raised my self-esteem. I have hope now where before everything was a failure. Life had no meaning.

Now that I am going thought the state pilot program I pray it does not end. I need this help. Dr. Cornish saved my life and I know there are thousands more in the casinos that he could save.

Dr. Cornish has helped so much. He is extremely professional and very well educated. I didn't have a chance for a higher education. He explains all my questions making sure I understand them. He is a person who is very much needed in our area of the state. I plead and beg that this program does not stop. With the help of Dr. Cornish and this program I have not gambled at all. I have no contact with anyone that I gambled with. I only carry $2 or $3 so I'm not tempted to go. When I have [the] urge to gamble, I turn it around to doing something better like planting a garden or seeing pretty flowers in bloom.

I see Dr. Cornish twice a week. His expertise has brought me out of the depths of hell. I get excited when my treatments come because every time I walk out of Dr. Cornish's office I feel better about myself. He is truly an amazing person. I pray every day that the program will continue and I can gain all of [the] benefits from it. Please tell the legislature that Dr. Cornish and the program have saved my life.

Thank you,
Faye

## TESTIMONIAL FROM A CLIENT

February 8, 2003

I would like to take this opportunity to thank the state of Washington for funding the Problem Gambler Treatment Program and giving me the opportunity to participate in it. I am grateful that the state has acknowledged there is a problem and has recently made this program available for people like myself. They say compulsive gambling is the “hidden addiction,” but I always saw the pain and anguish I felt reflected in other faces at the casino.

I have over the course of several years sought out what ever help was available in this area to people like me who suffer with a compulsive gambling problem, which is very limited. When I could not even get a sponsor trough the local GA group, I traveled to the Tri-Cities to attend meetings their in hopes of finding one. In fact, several years ago I voluntarily went though an IOP program designed for alcoholics for may gaming in hopes it would help.

The day I found out about the program being offered locally, I called the local provider. As it turned out, I was a former client of his. He was amazed when I called as he was in the process of printing me an intake forms and trying to locate my phone number. We had previously discussed the benefits of the treatment program currently being offered and looked into "in patient treatment centers” offering this program. The closest one was in Montana and not economically feasible for me. My insurance wouldn’t help with any of the cost. And being a compulsive gambler, I did not have several thousand dollars in my checking account

I am very hopeful now that I finally have the opportunity to find the help I have sought out and needed for several years. The mental anguish caused by my addiction has been overwhelming at times. I have caused immeasurable grief to those I love, yet they continue to believe in me, which has literally kept me alive at times.

I’ve known for years that being told repeatedly by a variety of counselors that “bad things happen to good people” wasn’t enough help. I had turned into a person I could never like or respect. There were days I could literally not look at myself in a mirror. And when I did, couldn’t recognize the person looking back at me.

Respectfully,

Jackie
Yakima, WA

## TESTIMONIAL FROM A TREATMENT PROVIDER

Olympic Addiction Services
549 McPhee Rd., S.W.
Olympia, WA 98502

April 11, 2003

To Whom It May Concern,

I have been seeing clients as a provider in the PGTP since November 2002. There have been many successes along the way. Of the five gamblers I have worked with so far, four have abstained form-placing bets since their initial session, and the other has significantly reduced her spending. I believe that due to the tremendous financial problems that pathological gamblers create for themselves, it is unlikely that any of the clients would have had the financial ability to access treatment without the PGTP. The families who seek help for them, while also attempting to engage their partner (gambler) in the treatment process, are given hope where there was none, and are empowered by learning about this addiction.

As the PGTP enters the final few months, I am hopeful that the state will have a clear understanding of the scope and severity of this addiction. I believe that the work that has gone on since the PGTP started can continue to provide services for those who so desperately need help.

Sincerely,

Steve, CDP, NCGC